MENTAL HYGIENE

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PSYCHIATRY IN COLLEGE

A DISCUSSION OF A MODEL PERSONNEL PROGRAM

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FOREWORD

DURING the last seven years, as Director of the Department of Psychiatry and Psychology at R. H. Macy's, New York City, I have had the opportunity of studying several thousand employees— a considerable percentage of whom were college graduates—and have become convinced that these young men and women did not commonly receive during their school and college careers that training which enables a man to make the greatest use of such ability as he possesses—the sort of training that is fundamental to one's balance in life and the healthy and effective functioning of one's personality; the sort of training that the psychiatrist sees in terms of a unified and well-integrated personality, capable of utilizing all its assets, which, experience has taught him, is not acquired through merely going to school. And yet the achievement of such a personality comes nearer than any other measure to being the index to a man's chances for success and happiness and should consequently be the index to his education.

The frequency with which these young people have met failure or defeat has raised in my mind the question of the purposefulness of a college education.

Did the college have a well-defined plan in connection with the development and training of each student? If so, just

what did it set out to accomplish? What facilities did it use in accomplishing this purpose? How planfully were they employed in the light of each student's individual abilities, adaptabilities, and needs? And how well did it achieve its end in each case?

An accurate answer to such questions might be most revealing from the standpoint of the usefulness of a college education, and might lead college faculties to inquire into what might be accomplished for the individual student if the entire college machine could be scientifically focused upon his or her greatest possible development, after a complete and well-rounded study of each person had indicated something of what these abilities, possibilities, and adaptabilities really were. (And here it becomes necessary to emphasize that psychological tests, though of a certain value, are relatively unimportant in the total study of a case. The deeper understanding of the whole personality, as gained through a psychiatric examination, is fundamental to any well-rounded program of personality development and, therefore, of education.)

While carrying on my work in industry, I have maintained as a hobby an educational experiment, a so-called psychiatric or mental-hygiene school where some fifty boys and girls of average or superior intelligence, but with personality problems, have been under individual training and treatment. The results achieved through a well-directed program in each case have convinced me of what could be done in college if the same general methods were applied to every student—if the personality and its organization and integration, and not just the intelligence of the student, were the goal.

Out of these two pieces of work there has come to me a philosophy of education that includes something far more definite in the training of young men and young women than the taking of prescribed courses toward a degree—something more individual and personal, something more related to one's ability to achieve in the realm of life's realities, something more concerned with the needs of the entire personality than is now conceived of.

V. V. Anderson.

INTRODUCTION

A committee of engineers was appointed by the American Institute of Mining and Metallurgical Engineers to investigate and arrive at an answer to the question: "What does industry look for in the college graduate?" A questionnaire was sent out to which numerous prominent managers replied. Their answers were pretty much alike, and could be summed up as follows: "Requirements of a technical subordinate are that he must have integrity and loyalty. He must be clean and a good citizen. He must be energetic and reliable. In addition, he should be well-grounded in the fundamentals of science."

It is to be noted that in these replies there was not a word about special courses in mine timbering, or flotation, or steel refining, or heat treatment, or the like, but that the answers had to do with the personality make-up of the applicant—and this, mind you, in a highly technical field where special training would appear to be the main issue.

These answers are typical of those given by employers in any line, whether in engineering or the department store, in the bank or the factory. It is the personality of the individual, the qualities of his mind and the traits of his character, the whole person, his habits and attitudes, and not the degree of culture or skill he has acquired, that underlie his success or failure.

Our own experience in the field of industry has convinced us of this irrefutable fact. Again and again it is obvious that it is the sort of personality make-up that the individual has achieved as a result of the resources of his particular college, and not the amount or type of information he has acquired, that is the real measure of the college's usefulness to him. If college life has enabled him to attain an adjusted and effective personality, then it has been of great constructive value; if it has not, then his education has been in a way purposeless. Thousands of case histories in our files go to prove that what industry asks of the college man or woman is an integrated, adjusted, and effective personality, and not what courses he or she may have taken in college.

An official prominent in the administration of the commercial high schools of New York City has expressed his wonder

at the regularity with which employers ignore the nature of subject matter in commercial high schools and emphasize character, sense of responsibility, initiative, and so forth, in the young graduate applying for employment.

To one who sees these issues outside academic walls, either in a personnel relation, examining thousands of young college people who are seeking occupational adjustment, or as a psychiatrist advising in personal, social, and domestic difficulties, it is hard to understand the failure of our educational institutions to emphasize the development and training of the whole personality as their ideal instead of resting content with the grades secured in chosen or required courses. We are not referring here to making good boys or girls, to preventing delinquency or mental breakdowns and so forth, but to a definite ideal in the case of each student which the college should consciously plan to achieve, a particular sort of product in every instance. That product is not only a healthy, well-adjusted personality, but a trained, capable, and effective individual. The college can and should deliberately seek to attain this by utilizing all of its resources in a purposefully directed way in each given case. This is a personnel job as well as a technical one, requiring the guidance and direction of the psychiatric and psychological sciences.

As one studies young men and women, all with the stamp of a college degree, one finds an enormous number who do not make good, who are discharged or invited to resign, and who go from one position to another seeking successful placement. In these cases one finds that the fault does not lie in an inadequate academic training or insufficient knowledge, but in qualities of the personality for which nothing constructive has been seriously and continuously attempted.

Every year hordes of young men and young women are turned out into industrial life whose work habits and mental attitudes, whose ways of meeting important life situations, and whose personalities are so immature and infantile as to invite shipwreck when they are faced with a job and the work difficulties of everyday life. No one who studies young college people in their daily occupational and social life can have escaped a feeling of distress at the failure of education to start with the known needs of the individual and to main-

tain a guiding and developing relationship throughout his college career.

It is like elaborating the obvious to state that those same issues of the personality that underlie the failure of the individual to perform effectively in his occupational life are operative in his adjustments to other life problems, are responsible for other sorts of defeat and shipwreck. Furthermore, few people measure up to their full capacity for achievement. Few people do as well as they have the ability to do. Most individuals do not utilize their mental faculties to the greatest possible advantage. Most people have not well-trained, well-ordered minds. This issue—the training of individual boys and girls in how to work and use their minds—is, it seems to us, of as much importance to education as the emphasis commonly given to subject matter. For instance, irrational thinking is not an uncommon characteristic of young people—or of older people, as far as that goes—and yet the educated man certainly should not so frequently exhibit this tendency.

It is impossible to state exactly the frequency of problem individuals in the various walks of life, but a run-of-the-mine study of the employees in an organization of some 12,000 people, who, before selection, had been thoroughly examined by a well-trained group of personnel experts, showed that 20 per cent were classified by the department heads themselves as problem individuals.

EXPERIENCE OF AN INDUSTRIAL ORGANIZATION WITH COLLEGE PEOPLE

A certain industrial organization with which the authors have been connected has for a number of years sent representatives to the colleges to interview young men and women about to graduate. To the most promising of these young people, they have offered employment on the "training squad," a special training course for the development of executive material. The group so selected has been given careful training in a number of widely different job environments, in order to orient them to the organization and to train them on jobs requiring various kinds of ability. After this special training, the young people have been placed on sub-

executive or "junior" executive jobs with the road open for further promotion. In other words, this organization has sought for young people with the ability, not merely to do a routine job well, but with potentialities for future leadership. It has been after its future executives.

At the end of eleven years, a check was made of results. Of 646 individuals admitted to training on this basis, 190 are known to have been unsuccessful, most of them within a period of six months. This represents about 30 per cent of the entire group admitted. (Mind you, these young people were selected by able business executives in coöperation with personnel experts in colleges.) This figure is a minimum, not a maximum; these 30 per cent are known to have been unsuccessful. It does not include an indeterminate number of young people who quietly resigned at the request of a superior—leaving no record beyond the reason the young executive himself gave as the ostensible cause for leaving. Nor does it include that "static" group, satisfactory in a limited job, for whom no promotion is expected—a group comprising about 20 per cent of all graduates of the training squad in the organization at the time of study. Though not "failures" in the narrow sense, these, too, stopped short of their goal.

The failures, furthermore, were not attributable to inferior intelligence, to poor health, or to lack of college education (issues that had already been settled to begin with), but to deep-seated character traits, qualities of the personality that a careful psychiatric study could have disclosed— not only for the industry, that it might have avoided selecting them, but for the college, that it might have done something toward reëducating them or, if this were not possible, at least toward reducing such liabilities and developing to the greatest extent such assets as each individual possessed.

What can one say as to the responsibility of the college for training the whole mind of the student when one finds that the qualities that differentiate the unsuccessful from the successful person are not his lack of knowledge and learning capacity, but his lack of adaptability, of purposefulness, of well-defined ambition, his poor work habits, and the like, and that these were present at the time of his admission to the squad and just after he left college? The unsuccessful

person was less alert than the successful person, with a more poorly developed sense of reality. In spite of the fact that he was a college graduate and with the background of college training, the unsuccessful person had frequently not acquired a habit of rational thinking. In the majority of cases, he suffered from personality difficulties—unresolved conflicts, repressions, alternating periods of optimism and despondency, feelings of inadequacy or insecurity, intense shyness, or self-consciousness. In fact, he was almost never a highly integrated personality. In those cases in which a well-integrated personality did become unsuccessful in this organization, we invariably found wrong placement, poor job supervision, faulty training, or work conditions for which the organization was responsible. But these cases were few.

The intelligence quotient of the unsuccessful group was, it is true, not quite up to the successful group's average. Yet three-fourths of the unsuccessful were of superior intelligence by psychological test (Otis). Clearly, lack of native intelligence cannot be blamed for the failure of this group. This point will be perhaps best illustrated by an actual case history of one young woman who possessed, not only superior intelligence and a college degree, but a cultured home background, social advantages, and a "lovely" personality:

Case No. 1—Unsuccessful

Miss Chaddock's good appearance and evident culture and refinement, her "sweet" personality, and her willingness to do any type of work impressed the employment interviewer as assets for selling. She was appropriately dressed and made a good first contact. An examination on the Otis test showed superior intelligence. She was, in addition, a college graduate. And she was willing to start at the bottom.

She was, therefore, engaged as a sales clerk, from which job she applied four months later for the training squad for executive training, and was referred to the psychiatric group for examination.

A physical examination showed her to be somewhat underweight, but otherwise in fairly good physical condition. A job-behavior investigation obtained by the psychiatric worker indicated a "lovely" personality as an outstanding asset. She had made good contacts both with customers and with superiors. However, there was no evidence of "push" in her performance, which was only fair if judged by the selling record itself. Supplementary psychological tests of judgment, speed, and accuracy disclosed no deficiencies.

But the personality study disclosed a poorly integrated personality, without purposefulness, showing no evidence of initiative and lacking stability as well as force—"a personality that would tend to become

'nervous,' tense, and tired under the pressure of a heavy volume of work."

The psychiatric group, in view of these lacks in her personality make-up, did not recommend Miss Chaddock for training, and specifically questioned her ability to "stand the pace that an executive has to stand."

She was, however, placed in training for executive promotion.

Less than two months after transfer to training, she resigned "for health reasons" from a stiff section-manager assignment. Across her record is written: "The heat floored her and she went to pieces."

In spite of the reason given for this young woman's resignation, Miss Chaddock's failure to "make the grade" was not caused by lack of health. There are scores of women in far poorer physical condition who stick it out pluckily through the heat of every summer on section-manager jobs. Miss Chaddock's entire career had shown this same lack of stability, an undue sensitiveness and "finickiness." And, obviously, failure was not due to lack of intelligence or to an inadequate amount of academic training. Failure was caused by qualities in this young woman's personality—lack of purposefulness, lack of stability, poor integration, poor work habits, inadequate insight—traits that will prevent her from tackling and carrying through activities effectively in any walk of life.

Although the unsuccessful person amongst our college graduates had not, on the whole, done so well in college as the successful person, all of our work has gone to show that the integrated and effective personality succeeds wherever you place him, in classrooms as well as in other places, and that the correlation to be established between brilliant college men and great success later on is not due so much to the college work he took as it is to the fact that a well-adjusted and capable personality tackles any job that he undertakes successfully, and that a poorly adjusted, poorly integrated personality fails to realize his possibilities in the classroom, at home, or in occupational life.

Tom Campbell is a case in point:

Case No. 2—Unsuccessful

Tom Campbell was convincing and alert in manner and made a forceful contact. He was self-confident, responsive, and expressed himself with ease and assurance. Without any personality study, he was taken directly on the training squad as future executive material.

In squad training, his manner was courteous, pleasant, and helpful. He was willing to step into any situation. He seemed to keep busy. His contacts were good. He showed himself generous, coöperative, and responsive in attitude.

On the other hand, he put things off. He was careless of details. He made decisions without taking the pains to think a situation through. And it was found that he could not be depended upon to finish up a job before leaving it for something else.

Near the end of his training period, he was referred to the psychiatric group for recommendation as to placement.

They found a man of good intelligence and a personality that apparently had always been seeking other fields that looked greener than the one he was in, who had been separated from his college for scholarship, and whose career had included other educational institutions, each of which he had left without finishing. His subsequent experience included accounting, selling the services of a paper-manufacturing plant, work on a farm, dealing in Ford cars, etc., etc., before he applied to this organization to try his hand at merchandising. He lacked integration and stability. He lacked a well-defined purpose and a clear insight into himself. Though at the time of study he was thirty-two years old, married, and with two young children, he was still experimenting to find work that he enjoyed. Lacking a "focused" personality, he could not be trusted to carry through responsible assignments, and the psychiatric group recommended that he be placed in a job with "maximum contacts and minimum detail"—where his responsive, likable personality, ease in contacts, and assured manner might be assets.

He was placed in a junior-executive location, where he did not make good, due to characteristics in his personality make-up that interfered with successful performance. He remained for barely six months and resigned because of "lack of advancement."

Tom Campbell is probably still seeking new experiences and greener pastures, finding "lack of advancement" in all of them. In spite of his scholarship record in college, Mr. Campbell did not fail because of an inadequate amount of academic training or inferior intelligence. The personality trends that caused him to be an unprofitable investment for this organization were responsible for the way in which he tackled his school work, his domestic responsibilities, and his job obligations throughout his career. It is a pity that these things were not recognized while he was in college, so that some constructive educational work might have been done upon this personality.

Successful executives are likely to have been active in some field outside of the college classroom. They are also rather more likely than the unsuccessful to have acquired some previous knowledge of their chosen field. To superficial think-

ing, it may, therefore, appear that there is a direct connection between later success and experience gained on the football field, or in occupational training, or in working one's way through college, as such. Our study of the group above mentioned does not confirm this, but only goes further to show that the *integrated person* acquires a goal and knowledge regarding his chosen field rather early in the game.

A study of several cases given below—three successful and one unsuccessful, but each with a record of achievement in college, each with some previous experience with business problems—illustrates the fact that the reason for success does not depend upon these things alone, but upon issues in the personality.

Case No. 3—Successful

John Dorsey's initiative, well-defined interests, adaptability, imagination, and purposefulness, and his well-integrated personality, are in evidence throughout his entire career, both in college and in business. His courses were deliberately chosen with reference to his goal. His social activities were healthy and constructive. He graduated with a scholarship record above the average and with an outstanding campus career, and immediately upon graduation he applied for a position in his chosen line of work.

An observation made of John Dorsey during training was that he "tackled each job with the same enthusiasm that he might have given a permanent placement." No task was given to him that he did not handle with effectiveness, and there was little question after a short time in training but that he would be an easy person to place. In fact, he found his permanent placement while on a training assignment in the office of a merchandise counselor. As a result of his performance on this assignment, the merchandise counselor requested his transfer to his group immediately upon conclusion of training.

He was promoted to a junior executive position, assisting in the merchandise office. From here, he was transferred to a junior assistant buyer's job in this same group. From this position, he was promoted to assistant department manager, and is at present considered to be a future department manager.

Minor defects in the personality can frequently be "ironed out" on the job—or, rather, successful performance in itself tends to increase the individual's degree of integration. But it is almost invariably true that an outstandingly successful individual has acquired, before the first job experience, an adjusted and effective personality, thinking processes that are already logical and highly developed, a good sense of reality, purposefulness, and the ability to focus the resources

of his personality on a given problem. This was true of George Dorsey, whose work history was given above. It was also outstandingly true of Mary Craighead:

Case No. 4—Successful

Mary Craighead's appearance, when interviewed for employment, was somewhat severe and plain. Although "satisfactory" from the standpoint of neatness and appropriateness, she had obviously not yet learned to make the best of her good points. In spite of this, she made a convincing first impression. She expressed herself well, and showed that her few months of experience in a Fifth Avenue store had given her a good orientation in the requirements of the work she sought. She was, in addition, obviously of good family background, she was a college graduate, and an examination indicated very superior intelligence.

She was accepted for training as executive material and was put on the "training squad." She entered the work with keen interest, staying until 6:30 or later "without a whimper." While in selling training, her poise, lack of distractibility, and good salesmanship were outstanding. On her first supervisory job, her executive ability and ease in handling the girls under her were remarked upon, although it was noticed that she became quite irritable with them when they failed to measure up to her standards. Furthermore, she aroused feelings of irritation and antagonism in certain of her superiors by her aggressive personality and "excess" pep and spontaneity. These same individuals stated that she was "likely to jump at conclusions."

Near the close of training, she was referred to the psychiatric group for examination and recommendation as to placement.

Personality study disclosed a hyperactive, very alert, responsive, and energetic personality, whose thinking processes were logical and highly developed, a young woman with an excellent sense of reality and considerable shrewdness, a high degree of imagination and initiative. She had not acquired a high degree of tolerance, and was apt to become impatient with and consequently to antagonize those whose thought processes were slower than her own. Nor had she yet overcome a tendency to short, intense "moods" of depression and of anger. However, her clear-cut thinking, her aggressive, observant, interested, and self-confident personality, and her initiative and energy were valuable assets and she was recommended for transfer to a junior executive position, as essentially excellent material.

She was put in a junior assistant's job. From this she advanced to assistant in the department. From assistant, she advanced to department manager. From department manager, she again advanced, ultimately to one of the most responsible positions in the organization.

Leslie Simmons, whose case is given below, was also intelligent—even brilliant. His college record well shows that he had enough ability to make good in this organization. It also shows that it is possible under present conditions for a young person to utilize the various resources of the college and to finish with high academic standing and outstanding campus

achievement without ever having learned to take responsibility for planning out a course of action or to focus his interest and attention toward a goal:

Case No. 5—Unsuccessful

Seemingly alert, courteous, sincere, Leslie Simmons made a pleasing first contact. His manner disclosed a cultural background and he gave the impression of superior ability, an impression that our psychological examination and his college record tended to confirm. He had been above average in scholarship, and was also active on the campus. He seemed, indeed, to have been interested in most phases of college life. His pleasing manner, evident cultural background, and apparent ability were obvious assets, and he was accepted for a section manager's job. This job he handled with such ease and tact that, when he applied for executive training, he was accepted and placed on the training squad without personality study.

In training he was industrious, so far as doing the work assigned him was concerned. He got on well with people and supervised well. So long as he was under supervision, where the lines of activity were laid down, he gave a good job performance, but it was noticed that he evaded responsibility for independent decision and constructive planning, that he effectively sidestepped all opportunities to think out his own methods and carry them through. Although he had applied for executive training, he appeared actually to prefer to have the thinking originate with some one else. He also completed his training period without giving any indication of enthusiasm or even interest in a particular type of assignment, and was referred to the psychiatric group for personality study and advice as to placement.

Personality study disclosed a complete lack of planfulness, purpose, or direction, a general "flatness" of his emotional life, both with reference to his occupational and his domestic and personal affairs. He had completed his four years of college with no idea as to what he wanted to do. He had thereafter taught French in a private school for a year or so; had then ventured into the cattle-raising business in Montana, had married, and had found cattle-raising neither as interesting as he had thought nor sufficiently remunerative to support a wife and two children; and had taken his wife and two children back East to look for a job—any job. He took the section-manager job with this organization because it was the first one that was offered. He had by this time been several years out of college, but still had no idea as to what he wanted to do. It is, therefore, not surprising that he did not "find himself" in the six months of training. There was no "drive" in his make-up, no well-defined aim or clear-cut ambition. His lack of a high degree of initiative and imagination, of planfulness and creative thinking prevented him from advancing. Psychiatric treatment was recommended, if he was retained. Executive placement beyond section manager was not recommended.

He was accordingly transferred back to section manager, the job from which he had been taken for training. After three months in this placement, he resigned. Across his record is written: "Physical and nervous wreck," etc., etc.

The career of Edward Brown is also of significance:

Case No. 6—Successful

By the time Edward Brown applied for his first permanent job, he already had behind him a background of dealing with people and putting ideas into practical operation. He had run a transportation system at the winter carnivals of his college. He had bought and resold student cars. He had taken boys to and from football games. He had been business manager of the college newspaper. During summers, he had acted first as sales clerk in a curio store in one of the national parks and later as assistant purchasing agent for the entire chain of such stores. And according to his own story, he had finished college with $300 more than when he went in, after earning his expenses throughout!

In addition, he had belonged to a musical club on the campus; he had been a member of an advertising society; he had been active in a fraternity. And in spite of an unusually heavy outside program, he had finished college with "average" scholastic standing. His first job was already "landed" before graduation—a job from which, within two years, he rose to the position of department manager.

He was accepted on our training squad, after a cursory interview, as promising material. He was successful in training.

The psychiatric study made at the end of this young man's training period showed an individual of good appearance and alert, active, energetic, industrious make-up, with a purposeful, well-directed personality, well integrated and with a definite drive toward achievement in whatever field he was placed. Though slightly introverted in make-up and with certain feelings of inadequacy and inferiority, he developed a very successful compensatory trend which served as a great drive in his personality to overcome tendencies that he considered faulty. He had insight and a well-defined goal and was recommended by the psychiatric group for a junior executive position in the merchandising division.

He was accordingly transferred on a temporary assignment to one of the merchandising departments, where he acted as sales clerk and assistant in stock upkeep. Here he gave the same performance that had characterized him elsewhere—he was attentive, meticulous in detail, watchful, interested in the stock, effective. The department manager requested his permanent transfer. He was transferred immediately on conclusion of his training, and given a position as head of stock (a junior executive placement) in the department. From this position, he was shortly promoted to assistant. From assistant, he was again promoted to department manager of the related department in an affiliated store—less than two years after employment.

The above cases are only brief notes from the studies of a very large number of college graduates who have succeeded or failed in this organization. Ultimately, it was decided that all applicants for the training squad would be seen by psychiatrically trained people and put through a formal study of their personality before selection.

This has enabled the organization to have a larger number

of high-powered executives and to cut down on its failures amongst young college people, so that now around 90 per cent of its placements according to psychiatric recommendation have, through careful follow-up, "made good." But on the other hand, what are the implications as to the sort of job our colleges are doing, if the following is in any way significant?

During the first year of the new employment procedure (1930), a count was made for a given period. The results were as follows:

> Of 344 college men and women who applied for the training squad and who were examined by the psychiatric group, 2 were sufficiently outstanding to justify employment on the squad. An additional 30, promising, but not considered ready for executive training, were accepted for staff jobs marked "promotional."
>
> This means that only *9 per cent* of these applicants were accepted for employment and only a little more than *½ of 1 per cent* were selected for executive training.

During 1930, a specially trained personnel representative was employed whose duty it was to visit the colleges and pick out before graduation the more promising young people from the graduating classes and encourage them to make application for employment with this organization, as well as to do a preliminary "weeding-out" process in the college. This personnel representative stated that in a count he made of 500 individuals interviewed at the colleges, he rejected *90 per cent* as not being effective, well-integrated, capable, promising people.

Those who passed the college selection process, or of their own accord sought interviews in the spring holidays of 1931, yielded the following data:

> Of 442 college men and women applying for the training squad, most of whom were already a selected group, 18 were sufficiently outstanding to justify employment on the regular squad. An additional 10 were accepted for a short summer-squad course, and 39 were accepted for staff jobs marked "promotional."
>
> In other words, approximately *15 per cent* of these applicants were accepted for employment and only *4 per cent* were selected for the training squad.

From the above figures, we may estimate that from *85 to 90 per cent* of applicants from the colleges are rejected by this organization for any job, and that from *95 to 99 per cent*

or more fail to be selected on the regular training squad as potential executive material (in the light of psychiatric study). To the business man as well as to the college faculty, a great many of these individuals look all right in their classes and on casual contact, but psychiatrically trained people who study their personality make-ups detect the mechanisms that commonly result in failure or at least in very slow development.

The successful type of executive came to the organization with the following personality: He was alert, intelligent, in good physical health, and with an abundance of reserve energy. He was of an active, purposeful, shrewd, adaptable personality, with good insight and a good sense of reality. He was well integrated, possessed well-defined interests, and had already shown some evidence of achievement in his career (had already shown leadership)—facts that were not necessarily obvious in a surface interview.

It is because of lack of such characteristics as these that this organization rejects from 85 to 90 per cent of applicants from the colleges. As to what the college should do for young people, it is clear from the previous discussion that something more than academic success, occupational training, or advice on the part of academic instructors is essential, at least so far as effectiveness in the everyday world of business is concerned.

Every student presents attitudes or habits or interests or other personality attributes that not only definitely affect his daily happiness and success, but that lay the foundation for future patterns in this direction. It is to these attributes in the personality of each and every individual that the psychiatric point of view in education should be directed.

HISTORY AND PRESENT STATUS OF MENTAL HYGIENE IN THE COLLEGES

The idea of mental hygiene or psychiatry as an essential part of college life is by no means new. In the early part of the century G. Stanley Hall suggested to one of the authors (V. V. Anderson) the possibility of introducing a service of this sort and courses into Clark University. And as early

as 1910, Dr. Stewart Paton, of Princeton, suggested that a psychiatrist should be part of every college faculty (22).[1]

However, it was more than a decade later that the first full-time psychiatrist was employed by a college, when Dr. Harry N. Kerns received appointment as a medical officer at the United States Military Academy, West Point (45). Dr. Ruggles was appointed at Dartmouth at about the same time (22), and in 1926 the Commonwealth Fund financed an experiment in mental hygiene at Yale (38). There was an early identification of psychiatric work in the colleges with the pathological or clinical aspects of psychiatry. Dr. Kerns (52) has stated that his "first cases were physical cases." Although at Dartmouth the psychiatrist examined cases of low scholarship and other problem cases, his work also was at first with the abnormal rather than with the normal student (52). At Yale, the department was from the beginning identified, both in its treatment and its prophylactic work, as an integral part of the school of medicine and the department of health (22).

This emphasis upon the abnormal rather than upon the average or superior student has continued through the growth of the movement. At present, less than ten years after the establishment of the first mental-hygiene service, the number of colleges and universities that have departments of mental hygiene has been estimated by Ruggles (45) to be 14. The number with psychiatric service available is estimated as 40 by Fry (22) in an article published early this year (1931).

Among the colleges reported as furnishing some form of psychiatric or mental-hygiene service are the following: Brown (15), Bryn Mawr (15), University of Chicago (15), Cornell (22), Dartmouth (22), Harvard (15), University of Kansas (38), University of Michigan (15), University of Minnesota (22), Mount Holyoke (34), Radcliffe (34), Smith (15), Vassar (15), University of Vermont (22), Washburn (22), Wellesley (34), Wesleyan (22), Wheaton College (47), University of Wisconsin (57), and Yale (15). Union Theological Seminary (15), the La Salle-Peru-Oglesby Junior College (35), and a number of preparatory and other schools could be added to the list—which should include 13 teacher-

[1] The numbers in parentheses refer to the bibliography at the end of the article.

training institutions, according to a survey recently made by Benson and Alteneder (6).

The personnel ranges from a consultant psychiatrist, available for seeing occasionally referred cases only, to the full clinical set-up of psychiatrist, psychologist, and social worker, giving full time to maladjusted and problem students with auxiliary courses and lectures to the student body and other related activities. The time has come when, as expressed by Dean Thompson (50), of Vassar, "it is not considered progressive to have an expert in mental hygiene on the staff. It is reactionary *not* to."

Whether expressed in the full clinical set-up or by a psychiatric consultant, the activities of the psychiatrist in the college have continued to be associated with the clinic. With the broadening of the psychiatric field, however, has come a growing recognition that the end of psychiatric work is "not a matter of preventing insanity" (37), but is "vastly more concerned with the mental health, the happiness, the efficiency of the average normal person" (54). Dr. Harrington (27), for some years psychiatrist at Dartmouth, states:

> "Mental hygiene . . . is a matter of providing each student with an environment suited to his own particular requirements, of seeing that he is not subjected to any stress or strain under which he will break down or suffer harm and that, at the same time, sufficiently heavy demands are made upon him to toughen his mental and moral fiber and to call forth the best that is in him."

Dr. Williams (54) gives, as the aims of mental hygiene in the college, the following:

> "1. The conservation of the student body; that intellectually capable students may not be forced unnecessarily to withdraw, but may be retained.
>
> "2. The forestalling of failure in the form of nervous and mental diseases, immediate and remote.
>
> "3. The minimizing of partial failure in later mediocrity, inadequacy, inefficiency, and unhappiness.
>
> "4. The making possible of a larger individual usefulness by giving to each a fuller use of the intellectual capacity he possesses, through widening the sphere of conscious control and thereby widening the sphere of social control."

Mervin A. Durea (19) considers that "mental hygiene is concerned with every medium or agency that influences or conditions human behavior." Dr. Smiley Blanton (9) defines

it as "a specific type of education, aiming not only to prevent failures and breakdowns, but also to help the average student to become more efficient"; and Charles D. Bohannon (10) makes the statement:

> "We should be interested, not only in the treatment of pronounced cases of mental disease . . . but also in discovering and eradicating the factors or elements in the college situation or environment which tend to render difficult the adjustment of the student to new situations."

Other progressive psychiatrists and educators have expressed this general point of view in recent years.

Parallel with this broadening concept of the place of psychiatry has grown a recognition[1] of the acute need for individual guidance, particularly during the college period. As has been pointed out, a number of factors contribute to the difficulty of adjustment at this time:

1. The physical changes and attendant social problems of later adolescence.
2. The sudden break with home ties and control, usually for the first time in life.
3. The immediate and overwhelming demand for self-direction.
4. The entering of a compact, impersonal community, which insists on conformity.
5. The forced, rapid growth, whereas in another environment growth would be natural and gradual.
6. The necessity for adjusting to a large number of new acquaintances, both desirable and undesirable.
7. The emotional upheaval attendant on the struggle to "make" certain societies or clubs or circles.
8. The intense competition and consequent injury to the self-esteem of individuals who are accustomed to superiority, and who frequently attain "average" standing or less for the first time in their lives.
9. The emotional conflict and bewilderment arising from discrepancies between parental ideals and college instruction, a conflict aggravated by the warped personalities too often found among college instructors.

These and other factors that contribute to the difficulty of adjustment during the college period have been repeatedly pointed out by psychiatrists and others interested in the mental hygiene of the college student. The results of lack of guidance at this critical period are indicated not only in studies of college graduates in business and industry, but in

[1] Among others, by Bain (4), Bohannon (10), Gardner (23), Groves (26), Harrington (28), Menninger (36), Sullivan (47), Thompson (48), and Williams (55).

studies made of college men and women during the undergraduate period.

In a study of 1,300 freshmen men at the University of Minnesota, Morrison and Diehl (39) found *17.8 per cent* with a history of abnormalities serious enough to indicate the need for mental-hygiene treatment.

In a brief neuropsychiatric examination given to more than 1,000 students at Harvard, Stanley Cobb (14) discovered *16.4 per cent* of the entire group with a history indicative of a neurotic condition.

After a study involving more than 1,000 unselected senior and junior students of Wisconsin, Dr. Blanton (9) estimated that *10 per cent* of the student body had maladjustments serious enough to "warp their lives and in some cases cause mental breakdown unless properly treated."

"An intensive study of one hundred and four unselected college students, juniors and seniors," Dr. Blaton continues, "gave the following results:

"Eighty-five	suffered from self-consciousness, timidity, stage fright, fear of reciting, or anxiety when meeting people. These attitudes were so well marked that the students themselves felt that they constituted a severe handicap to their social adjustment.
"Seventy-four	had feelings of insecurity, inadequacy, or inferiority so definite that they felt handicapped by them.
"Seventy-two	had friction and conflicts with either one or both parents so marked that it made them distressed and unhappy.
"Fifty-five	had problems relating to their love and sex life that needed adjustment.
"Fourteen	had religious problems.
"Fourteen	were upset because they had chosen the wrong vocation or did not know which one to choose.

"This was a study, not of abnormal students, but of an average group of college juniors and seniors. They wrote their life histories and this was followed by an interview in each case. There is no reason to think that any college group would show more normal adjustments."

Dr. Pressey (43), in a study of 100 women undergraduates at Ohio University, found all but 12—that is, *88 out of the 100*—with at least one problem which they considered to be

serious. "Every student reported at least one problem; the median number was three."

Dr. R. C. Angell (2), in a study in undergraduate adjustment recently published, found only 14.4 per cent of the students with what the mental-hygienist would term a good life adjustment. That is, approximately *86 out of every 100* of the individuals studied had not attained such an adjustment. Of these, 15.3 per cent were adjusted, but "on a basis of habitual and traditional patterns" rather than on a rational basis; 56 per cent had "broken with traditional patterns," but were not re-oriented; and *14.4 per cent* were badly adjusted personalities—so badly adjusted, in fact, as to be "unable independently to effect adequate adjustment."

From these and similar studies, conducted on widely separated campuses, it would appear that approximately *85 out of 100* students show their need for guidance in adjusting to the college situation, and that from *10 to 15 or more* are so badly in need of such guidance that they are in danger of developing serious disorders without it.

It is true that statistics never tell the full story. As Bain (4) remarks of college students, "most of them weather the storm after a fashion. The vast majority soon return to the conventional irrational security of the mob from which they were momentarily shaken. . . . Some integrate their personalities on a saner, more wholesome, rational level. But some do not. . . ." And even those who do might have acquired a richer, better-rounded, and more effective personality had they had the intelligent guidance needed at this critical period. Of the college experience, Williams (54) exclaims: "There is not one of us but has his psychic scars of this period."

The preceding references make it clear that the need for individual guidance for the "normal" college student has been fully demonstrated and is recognized by the colleges. In fact, a great many colleges have guidance of a sort, but not the sort of purposeful guidance that is based on a scientific and technical knowledge of the needs of the individual's personality and a technically worked-out procedure for the fullest development of that personality.

The means developed by the psychiatric group to meet this

need was, first, to supplement clinical treatment of "problem" cases with personal talks between the psychiatrist and all students who wished to confer, whether considered "problems" or not (52). This obviously reached only a small minority of students, and only those who had outstanding maladjustments—often the very sick student.

Means taken to get in touch with the "average" student have included mental-hygiene lectures, either in connection with the regular hygiene course (7) or special lectures to the freshman or the student body by the psychiatrist (52); required courses in mental hygiene for all freshmen; and optional courses for upper-classmen (52). In an attempt to obtain a knowledge of the individual, an autobiography was required in one college (7) of every member of the hygiene course. These autobiographies were read by a psychiatrist and individual needs were determined thereby. In another college (52) the freshmen and sophomores have been requested to fill in a questionnaire designed by the psychiatrist, and this questionnaire is used to determine individual needs.

While such methods have value, they do not, of course, modify the situations that add to individual difficulty and maladjustment, and they do not allow for the personal contact, technical study, and personality guidance with each individual student which is a clearly indicated need. The personal contact obtained through ten-minute talks to each entering freshman (22), or through "smokers" for small groups of students (48), developed in an attempt to meet this need, does not allow for genuine individual guidance in the light of any thoroughgoing information about the student.

Recognizing this, the psychiatric group in the college has developed a further method—that of conferences with members of the staff who do come in direct contact with the students—conferences designed for the education of this staff in mental-hygiene methods (48).

In the meantime, those groups that have direct contact with student problems have also recognized the need for individual assistance and guidance, and "personnel bureaus" have been established; "counseling" services have been organized, either independent of or supplementing the deans' offices; "faculty advisers" have been appointed for each student;

"conferences" of students with sponsors of one kind and another have been arranged; the Big-Brother and Big-Sister and the proctor systems have been adopted by various progressive American colleges. In most colleges to-day, some sort of attempt is made to advise the student; in the larger colleges, there are usually several agencies. "The college man of to-day has five helps where his father had one in making the transfer from old to new outlooks on life." (5).

In no place, however, does this seem to be done in the light of a technical knowledge of all the factors involved in the adjustment of each individual. The very multiplicity of counseling efforts, in the hands of untrained or uncoördinated workers, may well work harm and add to the student's bewilderment and maladjustment. Miss Bragdon (13) speaks of a hypothetical student for whom part-time employment is obtained by the personnel bureau to relieve a financial situation; who is in the same week told by her faculty adviser that more time must be given to a certain subject if she is to avoid probation; and who during the same week is advised by a member of the hospital staff that it is imperative that she find additional time for rest! Such a young woman, unless her maladjustment became so acute as to render her a serious mental-health problem, would in all likelihood not come to the attention of the psychiatric group.

Psychiatric work, if it involves treating the individual alone, could never completely cure the person or solve the problem. Nor is the need met by multiplying the number of bureaus and types of student aid. The lack of integration, the lack of relatedness in these agencies presents just as much of a problem as does the maladjusted student himself.

Mental hygiene needs to enter college, not as one more bureau or guidance program, but as a philosophy in education and as an integrating agency for bringing together all those resources and counsels that seek to guide and develop the individual student. The means by which this philosophy may take form is discussed in the following pages.

SUGGESTIONS OF MENTAL-HYGIENISTS ON THE PROBLEM

Recognizing that the need has not been met by present measures, a number of recommendations have been made by

mental-hygiene and related groups for widening the scope of their activities. The brief summaries given below are not intended to be comprehensive, and are presented merely as indicative of the trend of thinking in connection with this problem:

Dr. Beard (5) considers "mental prophylaxis" to be a four-fold problem:

1. The teaching of hygiene.
2. The provision of an adequate environment.
3. Alertness to insure that both instruction and surroundings are effective.
4. The opportunity for those who want it to consult with a psychiatrist.

Dr. Groves (26) considers that a mental-hygiene program should include:

1. The handling of difficulties in clinical case-work.
2. The prevention of difficulties by means of such activities as:
   a. Selection of freshmen.
   b. Lectures to the student body.
   c. Conferences with personnel and faculty advisers.
3. The education of the faculty, "too often psychopathic themselves."

Appel and Smith (3) consider that college mental hygiene has three aspects: (a) the therapeutic, (b) the preventive, and (c) the constructive. In order to carry out a mental-hygiene program, they recommend the following:

1. Explanation to the faculty of the purpose of mental hygiene, and a reading list for the faculty.
2. Appointment of a committee (of which the psychiatrist should be a member) to handle all discipline and scholastic problems.
3. Lectures to the student body.
4. Seminar courses in mental hygiene.
5. Clinical and personal contact with the student body.
6. Centralization of personnel records.

Smith (46), however, considers that the logical place from which to direct a college mental-hygiene program is the medical department.

Bain (4) offers the following as essential to an effective mental-hygiene program:

1. Every college should have a psychiatric staff.
2. Every freshman should have a good mental-hygiene course.
3. The chairman of the disciplinary committee should be a psychiatrist.

4. A psychiatrist should be present at the physical examination of each student during his first year and once a year thereafter.

5. Failing students should be automatically referred to a psychiatrist.

6. Deans of men and women should be required to be well-grounded in personality maladjustment.

7. Advisers should be more concerned with life schedules and less with class schedules.

8. Teachers and friends should be allowed to refer problem individuals.

9. Students with problems should be permitted to come for advice voluntarily.

10. All teachers should take one mental-hygiene course each year.

Dr. Ruggles (45), of Yale, recommends that research work be conducted by the mental-hygiene unit "to the end that we understand more nearly certain of the potentials that we must stress, not only in our selection of students, but also as an integral part of our whole educational program"; in addition, that the unit conduct "round-table conferences" and "lectures on mental hygiene," "teach understanding of human beings to the faculty," and "work toward an integration of the whole program during four college years." In spite of such a broadening of activities, Dr. Ruggles considers that such a unit should be "an integral part of the department of health."

Dr. Harrington (27), pointing out that mental hygiene is "obviously not a job for one individual . . . but of everybody connected with the institution," suggests "breaking up the entire student body into groups of convenient size" and then providing "proctors or counselors from younger members of the teaching staff to work under the direction of the mental-health officer"—each counselor to "live in dormitory with his men, eat his meals in the dining room, and smoke his after-dinner pipe in the common lounge"; each counselor, moreover, to be "provided with all data available" on his students, to "make a careful study of each student in his group," and to "follow this group through their college careers." Difficult problems are to be reported to the psychiatrist, complete notes submitted to him, and "staff conferences held at regular and frequent intervals."

Dr. Smiley Blanton (7) states:

"The mental-hygiene approach began as a method of dealing with the problem case. As work progressed, realization came that the normal person should maintain his mental and emotional health. . . . In the

> same way, mental hygiene is becoming an integral part of the colleges, dealing with the normal student. . . .
>
> "The question of how to contact all the students is a ponderous one in a large university, in view of the short time. . . .
>
> "Mental hygiene can be included in a course in hygiene and problems uncovered here can be treated individually. . . . Mental hygiene can make its contribution to vocational guidance. . . . The mental-hygiene division can study students and steer them to other departments. . . . It can conduct a study of successful students, to ascertain causes for their successful adjustment."

Dr. Blanton has also recommended "the establishment of a student advisory service" for "the coördination of all college activities concerned with mental health and emotional adjustment"—"a clearing-house between faculty and students." He recommends that the mental-hygiene division should "study and advise in regard to all overt problem cases," "conduct courses in mental hygiene," "consult with each student in mental-hygiene courses," and "coördinate vocational guidance with other phases of emotional guidance."

Miss Bragdon, at the conclusion of her book *Counseling the College Student* (13), also recommends the "coördination of all agencies working in behalf of the welfare and development of the individual college student." She adds that "the person who coördinates all personnel activities must become a generalist. . . . He cannot remain primarily a specialist. . . . To what official and office this general coördination, with the counseling process as one of its major functions, should be assigned, should depend upon the organizational structure of the institution concerned." This coördination may be effected in the office of the dean, or under "a psychiatrist willing to become a coördinator," or by "a faculty committee with its chairman giving up a good part of his teaching." "The deciding factor . . . is not title or office, but criteria and standards," including "flexibility of organization," "a central location," "a reputation of general interest in students," and "a status of sufficient prestige to enable coördination to be accomplished."

"The most logical approach of a head counselor to the whole program of student counseling," she continues, "is in the rôle of educator, dealing with educational problems . . . for in the last analysis he is counseling . . . toward the

primary purpose of the college—the development and stimulation of scholarship, with its necessary accompaniment of general development."

Our own personal point of view is, first, that the primary purpose of the college should not be the stimulation of scholarship, but the training and well-rounded development of the individual student; second, that the general development of the individual is not necessarily an accompaniment of scholarship (too often, scholarship is related to the highly ineffective, neurotic, and maladjusted personality); third, that the main question is whether the coördinator and director of such activities should be a man trained in subject matter, curriculum organization, and educational principles or a man trained in the study and evaluation of the human personality; a man trained in technical matters about school courses and subjects or a man trained in technical matters about individuals—an educator or a psychiatrist.

It seems to us that education is ready to take a step in the direction of greater emphasis on the individual; has become increasingly conscious of those extra-curricular problems that dominate the life adjustments of all students; and has already in most progressive institutions created some facilities for counseling and advice.

In no place have we found anything like a sound, scientific attempt to undertake a thoroughgoing and well-rounded routine study and evaluation of the human material that colleges deal with, or of the educational and other facilities employed in the light of the varied personality needs of this material; nor is there a scientific integration of educational and other resources utilized for the student's development, so far as they bear upon the individual's own case record, his possibilities and educabilities, his training program, and the final results achieved in his case.

One finds many colleges equipped with various agencies and departments—personnel departments, health departments, psychological departments, mental-hygiene departments, dean's office, and so forth—all with the idea of doing something helpful for the student, but universally so unrelated and uncoördinated as to fall short of the greatest possible benefit to the individual. Nowhere have we seen the sort of

unified, related, consistent, comprehensive, singly directed, and scientific personnel program that would result in a thoroughgoing study, complete understanding, and adequate development of all the potentialities of the individual student.

An integration of all these facilities in college so far as they bear upon each undergraduate should be aimed at, a concentration of all personnel resources, a coördination of records to the end that a scientific educational plan for the individual may be outlined, a thoroughgoing case study, together with the sort of personality follow-up that the psychiatrist has demonstrated to be necessary for scientific guidance. This, in our opinion, can be properly accomplished only through the personnel department, which should be made up of the psychiatric and mental-hygiene department of the college, and should be equipped to do a technical job so far as concerns studying and advising in individual cases (and here, of course, we are not referring to problem cases).

It is obvious that a coördination of records such as that suggested would not only furnish the only sound basis for working toward the greatest individual development of a given student, but would make possible an accumulation of scientific data for the planning of college courses and the organization of college life on the basis of factual material rather than the empirical judgments of faculty members.

THE PROGRAM

1. Our program would provide that psychiatry or mental hygiene be located in the personnel department as an educational agency rather than in the medical department as a health agency.

2. Our program would conceive of education not only in terms of knowledge acquired or of culture or of scholastic attainments, but in terms of the greatest possible development of the whole individual—not alone of his intelligence, but of his entire personality.

3. Our program would keep the mental-hygiene group engaged with the possibilities to be achieved in the case of every student and not merely with the treatment of the abnormal.

4. A complete psychiatric study of the personality, which

would include the candidate's educational achievements as well as all other data in his life career and constitutional make-up, would be made the basis for college entrance.

5. This personnel group, having surveyed thoroughly and made analyses of the entire organization and the operation, the facilities and resources of the college, the courses offered, and so forth, would in the light of the initial psychiatric and personnel study guide the new student in all of his college placements.

6. Our program would provide for a systematic and continuous follow-up of the performance and the adjustment of each and every student, in order that further insight into his problems and needs might be gained and advice given. Psychiatric treatment of the maladjusted personality, and information and counsel leading toward the increased efficiency of capable individuals, would naturally be part of the program.

7. The psychiatric or mental-hygiene or personnel group would become the counseling and advisory center, not only for scholastic issues, but for all the life-adjustment problems of the individual student. This group would naturally utilize facilities already existent in the college in the way of faculty advisers, and so forth, as part of the machinery for accomplishing its purpose.

8. Such a department would carry on courses in the field of mental hygiene, both for the student body and for faculty members.

9. Such a department would carry on continued investigation into the reasons for success and failure among college students during their college careers, in order that preventive work and more purposeful training might be instituted.

10. Logically this group, in the light of a carefully detailed case record covering the four years of college life and the intensive study and close personal contact they have maintained, would be prepared to give occupational and vocational counsel to the individual based upon the known facts about his possibilities.

11. Finally, our program would provide for vocational research through follow-up studies of the later careers of graduates, in order that information might be secured relative

to those features, both constitutional and environmental, that had to do with the individual graduate's success or failure in his occupational life. Thus the department would become increasingly valuable to the undergraduate group as a vocational counseling center.

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PSYCHIATRY IN THE COMMUNITY *

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AS a fund of knowledge and also as a part of the art of medicine, psychiatry is to-day a topic that is of interest, not only to us as psychiatrists, but to the community at large. This interest of the public is due, not only to special efforts at the promulgation of information on mental disorder and mental hygiene, but, we believe, to the general increase of interest in public health and sociological problems. If at times we have doubts as to the desirability of this situation, because of the obvious misinformation and miseducation of the public in matters of psychiatry and mental hygiene, I think we should remember that in all matters of public health the uninformed rush in where the informed fear to tread, but that interest, even if misdirected, is a hopeful sign, and that in the end the truth will prevail.

In medicine we learn of causes and methods of prevention through the study of pathology. It is generally conceded, we believe, that psychiatry has had an important field for a good many years in the care and treatment of mental disorders, largely in public or private hospitals, but it is frequently asserted that the activities and interests of these hospitals and of the psychiatrists in them have been confined within the walls of the hospitals and that little, if any, concern has been felt with regard to prevention, or what might be called mental hygiene. Such a belief does not, we believe, give credit to the intelligence of physicians who might be expected to be, and who have been, from their early training imbued with a conception of the importance of following through the study of pathology to the development of prevention.

> "Until within a comparatively recent period, insanity was treated by medical men very much like other diseases. Regarding it only in its physical aspect, they considered their duty as finished when they had

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exhausted the kind of medication supposed to be most efficacious for the purpose. But in an age of active philanthropy and of great practical sagacity, the idea was not long in making its appearance that something more is necessary to insure the highest success, even to the medical treatment. . . . the idea began to prevail that the insane could be best managed in establishments devoted exclusively to their care. . . . The beneficial results expected from special hospitals for the insane have been abundantly experienced, and the benevolence of the age has been largely engaged in establishing them, until they have become firmly rooted in the necessities and affections of every Christian community."

"If it is true, then, that, in the various stages of its progress, the mind, like the body, is under the government of inflexible laws, it follows that these laws should be thoroughly understood, in order to obtain the highest possible degree of mental efficiency. To show exactly what they are, to exhibit the consequences that flow from obeying or disobeying them, is the essential object of *mental hygiene*, which may be defined as the art of preserving the health of the mind against all the incidents and influences calculated to deteriorate its qualities, impair its energies, or derange its movements. The management of the bodily powers in regard to exercise, rest, food, clothing, and climate; the laws of breeding, the government of the passions, the sympathy with current emotions and opinions, the discipline of the intellect—all come within the province of mental hygiene."

These two quotations are not from recent discussions or formulations, but are taken from the book *Mental Hygiene*, published by Dr. Isaac Ray[1] in 1863. Dr. Ray was superintendent of Butler Hospital in Providence and spoke from his experience as superintendent of a psychiatric hospital. We believe that his use of the term mental hygiene and its definition, and his book in general, are of interest not only as exemplifying the wide interest of a hospital psychiatrist in the community, but also as showing that a conception of mental hygiene and the use of the term did not originate in the present century, as many workers of to-day feel. Many of Dr. Ray's conceptions of mental hygiene appear just as applicable to-day as they did in 1863. He decries, for example, the rigidity of education in schools along much the same lines as those who criticize it to-day, and the increased stress and strain of the life of his time, with their destructive effects on mental health, are commented on as they are to-day.

Dr. Ray's book was not the first book written on mental hygiene. Preceding him, in 1843 Dr. William Sweetster[2]

[1] *Mental Hygiene*, by Isaac Ray, M.D. Boston: Ticknor and Fields, 1863.

[2] *Mental Hygiene*, by William Sweetster, M.D. New York: J. and H. G. Langley, 1843.

published a book entitled, *Mental Hygiene or an Examination of the Intellect and Passions,* in which he emphasized the reciprocal relations between the mind and the body. To quote briefly from him:

> "A knowledge of the secret troubles of our patients would, in many instances, shed new light on their treatment, or save them, at any rate, from becoming the subjects, if not the victims, of active medicinal agents."

And again:

> "A knowledge of the secret troubles of our patients would, in many each other should instruct the physician that all his duties to his patients are not comprised under their mere physical treatment, but that he is to soothe their sorrows, calm their fears, sustain their hopes, win their confidence; in short, pursue a vigilant system of moral management, which, although so much neglected, will, in many cases, do even more good than any medicinal agents which the pharmacopœia can supply."

In discussing the relation between emotions and bodily function, particularly that of the gastro-intestinal tract, he points out a practical method of mental hygiene which we do not hear so much of to-day—that is, the approach through the cook. He says:

> "It is obvious, then, that the cook will often have far more concern in the domestic tranquillity of families than human philosophy has yet suspected. And would this important functionary but cultivate his art in reference to the facility of digestion, as well as to the gratification of the palate, he might contribute more to the happiness of society than nine-tenths of the boasted moral reformers of the time."

Dr. Sweetster, like Dr. Ray, stressed the rush and unrest of the period as a factor in the production of mental disorder much as we do to-day. Thus he says:

> ". . . the demon of unrest, the luckless offspring of ambition, haunts us all, agitating our breasts with discontent, and racking us with the constant and wearing anxiety of what we call *bettering* our condition. The servant is dissatisfied as a servant; his heart is not in his vocation, but pants for some other calling of a less humble sort. And so it is through all other ranks—with the mechanic, the trader, the professional man—all are equally restless, all are straining for elevations beyond what they already enjoy; and thus do we go on toiling anxiously in the chase, still hurrying forward toward some visionary goal, unmindful of the fruits and flowers in our path, until death administers the only sure opiate to our peaceless souls. That the people of every country are, in a greater or less measure, the subject of ambition, and desirous in some way of advancing their fortunes, it is not, of course, intended to deny; yet owing to the circumstances already mentioned, the remarks just made apply most forcibly to ourselves. These same national con-

ditions, too, which are so favorable to the increase of ambition, render us particularly liable to great and sudden vicissitudes of fortune, which are always pernicious both to moral and physical health."

Sweetster gives an interesting description of the tendency to live in phantasy, with loss of contact with reality and progress at times to delusional formation and incapacity. He adds:

"Among the best securities against this periodical ascendancy of the fancy, and those uncomfortable nervous infirmities which so generally accompany it, I may briefly mention a life of active employment, directed to some interesting object. It would seem, indeed, necessary to the health and contentment of the human mind, at least in its cultivated state, that it be constantly actuated by some prominent and engaging motive, by the feeling that existence has a determinate purpose."

Further, he advises:

". . . to guard ourselves from the afore-named moral infirmities and their concomitant physical ills, we should cultivate a contented spirit, confining our wishes and expectations within the limits of reason; and especially striving against the morbid growth of ambition, which, when from the temperament or other circumstances of the individual it does not impel to active efforts for its gratification, will cause the mind to be ever wandering amid visionary scenes of wealth and honor, and thus wholly disqualify it for its appointed sphere of action, and enjoyments. Nothing, let me add, contributes more effectually to advance our mental, and, as an established consequence, our bodily health, than a suitable interest in the duties which belong to our several stations."

In his book of 1863, Dr. Ray discussed the increase of mental disease in the community, and in another book entitled, *How to Enjoy Life or Physical and Mental Hygiene,* by Dr. William M. Cornell,[1] published in 1860, the superintendent of the "lunatic asylum" in Utica, New York, is quoted as stating that "insanity is fearfully on the increase in this state," and that recently within five days seventeen patients had been admitted to that institution, the greatest number ever before admitted in so brief a space of time.

At the risk of appearing to diverge from our topic, we have referred to these discourses on mental hygiene presented many years ago to recall to our minds that the problems of psychiatry that we see to-day are not new, that their solution has not been reached, and to indicate from past experience that in all probability all of them will not be solved in

[1] *How to Enjoy Life or Physical and Mental Hygiene,* by William M. Cornell, M.D. Philadelphia: James Challen and Son, 1860.

the near future. We have made advances in scientific investigation and we know more of specific causes and treatment than we did fifty years ago. We like to feel at the present time that we know a great deal about etiology and methods of prevention in psychiatry, but we should be concerned that the wish to know does not lead us into a conviction of knowledge.

In a recent communication on the psychosexual development of the child, which is described as a resumé to aid the clinic worker to a better understanding of children with behavior problems, the statement is made that when a child's nursing experiences have been unduly curtailed, because of physical deformity in the mother's breast, physical difficulties of the mother, or for other reasons, "the child remains constantly unsatisfied and as a result develops the reaction pattern of always feeling slighted and wanting more. Such an individual will meet every situation with an underlying feeling that no matter how well things turn out for him, he will not get all that he deserves." On the other hand, we are told, when a child has been nursed longer than the optimum time, with a supply of milk that has been overabundant so that it requires little or no effort on his part to obtain gastric satisfaction, the individual develops a corresponding reaction pattern and "tends to go through life feeling that, whatever happens, he is sure to get everything he wants with little or no effort."

How such an isolated experience in an infant can be logically concluded to be the cause of later personality reactions after a period of years, it is difficult to see. To our mind it indicates a disregard of the possibility of other causative influences and smacks of wishful thinking, suggesting that the writer has put himself in the situation and drawn the conclusions from his own subjective experience. The wish is to have things settled, problems solved, or to have a ready answer to questions about various causes.

We cite this as an example of that type of thinking which reflects on psychiatry as a body of knowledge acquired from the study of observable facts carefully controlled. Such thinking, used for the education and instruction of the uninformed, does not, in our opinion, promote the interests of psychiatry or add to the reputation of those who practice it.

Psychiatry is accused at times of being infiltrated with hocus-pocus and with mysticism, and it will advance psychiatry if those who are presumed to have its interests at heart refuse to accept and promulgate as truth philosophical speculations that cannot be proven by the methods of scientific investigation and that are contrary to common sense. If psychiatry promises what it cannot reasonably and logically expect to carry out in the way of treatment and prevention, and inculcates faith in these promises among lay persons who spread the promises far and wide, the reaction will be an unfortunate one and will include those who are working carefully and conscientiously in the field, with a background of sound clinical experience, and who are not carried away by the adulation and emotional transferences of an unstable public who are satisfied with nothing less than final, easy solutions of problems, in order that they may avoid the unpleasant necessity of thinking things through and waiting for the slow accumulation of facts.

As one of its main functions, psychiatry should still look, we believe, to the training of the medical student and the education of the physician, who remains or should remain in the front ranks of the army of attack on mental disorder and the prevention of mental disorder and maladjustment. If the medical student is adequately trained in the understanding of psychiatric principles through clinical observation and is imbued with an understanding of the importance of the treatment of his patients' attitudes, not only toward disease and sickness, but toward life, much can be accomplished not only in the treatment of mental disorder, but in the prevention of disabling attitudes that reduce efficiency and promote disharmony. We are not satisfied at the present time, and in fact were not satisfied in previous years, with the presentation of advanced mental disorders as the entire course of training for the medical student. Present facilities, with the close approximation of psychiatric teaching centers to general hospitals, give the student an opportunity, not only of examining patients with established mental disorders and becoming familiar with their life histories, but also of receiving training in the psychiatric approach to patients in general hospitals, with an evaluation of attitudes toward illnesses and their prognostic implications. Such general-hos-

pital psychiatry may in the opinion of some persons be superficial, but in our opinion it is an important supplement to the clinical psychiatry obtained in the psychiatric hospital, inculcating on the medical student an attitude that should be most helpful in the practice of medicine.

The problems of the interrelationships between psychiatry, social work, psychology, and sociology cannot be solved in a final way at the present time. Psychiatry is interested in the problems in which these other disciplines are concerned in so far as they involve human relationships and maladjustments. It is not, however, prepared, nor does it wish, to take over the activities of these branches of social science. Each can contribute its part to human betterment, but exactly what the respective contributions and fields of activity should be can be determined only after continued study and the coöperation of the persons concerned, with their respective interests and training. We submit the thought that a more or less fluid relationship between these various branches is not necessarily a detriment, but rather may be conducive to more progress than if exact definitions were set up, since definitions often mean a limiting and constriction of activities. A static condition may result and stimulus and curiosity for the extension of knowledge may be inhibited.

We have the conviction, however, that the treatment of mental deviations, with their intimate mental and physical interrelationships and symptoms, remains within the province of the science and the art of medicine and that psychologists or other lay workers with an academic education and perhaps a short course of lectures on psychiatry and mental hygiene, or even with certain clinical contacts with psychiatric problems, cannot thereby arrive at an adequate understanding of the causes and symptoms of mental deviations or be prepared to treat them properly.

A university student whom we recently saw had been referred to a psychologist because of complaints of loss of interest and of power of concentration. He reported that the psychologist had indicated to him and convinced him that he had a superiority complex and that it rested with himself to solve this situation. We found that he had the characteristic history and symptoms of a retarded depression. His father had had recurrent depressions, eventually ending

in suicide. There were the common symptoms of loss of appetite, with insufficient eating and constipation. We considered it more essential to establish him in the first place in a definite physical régime than to emphasize the importance of an alleged superiority complex. Because of your own similar experiences, I assume that it is quite unnecessary to cite further instances of the evident need of the medical approach in psychiatry.

It is hoped that, as time passes, more thorough understandings may be reached. Meanwhile it seems important to avoid as far as possible, in our contacts with others interested in social problems, those emotional reactions which are apt to arise when we seem to be deprived of something that we think belongs to us, or when we are told that we cannot have something that another person has and that we think should be given to us. Educators rightfully believe that from their long experience they have a certain knowledge and understanding of pedagogical principles, and a criticism of their practices as ill advised and non-constructive naturally arouses a feeling in them that persons without adequate experience are trying to preëmpt a field that cannot adequately be occupied by them. Such criticisms, of course, bring about in us as well as in others resistance and defense reactions, and we as psychiatrists should know that a destination can be more quickly and happily reached by accompanying a person on the way than by driving him.

For those who are perturbed at the lack of immediate solution of all the problems of human relationships and who become stirred with the feeling that something should be immediately done about something, we commend a perusal of the works of the mental-hygienists whom we have quoted above, with the hope that as a result of such perusal a more reconciled mental-hygiene attitude may be attained.

THE PHYSICAL AND THE EDUCATIONAL PROBLEMS CREATED BY PROLONGED ILLNESS *

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THE point of view presented in this paper is based on experience with children whose nervous systems are not working smoothly from any one of a number of causes. Incidentally, I am involved in attempts to find methods of training and educating children who are out of step in ordinary schools. These interests have brought me into contact with teachers, psychiatrists, psychologists, and psychiatric social workers, as well as with children and their parents.

During these conversations I became interested in vaguely defined fields of endeavor known as "mental hygiene," "child guidance," "child study," or what not. Unfortunately it is extremely difficult to define these terms, because one finds that efforts are being made to restrict their use to specific types of enterprise. If, however, all these efforts at segregating fields of interest and establishing leadership are ignored, it is possible to discuss the place of the practitioner of medicine in a coöperative and fairly well-integrated plan of child management.

As I see it, "child guidance" is nothing more nor less than education. "Mental hygiene" has a medical tinge, and since the name was actually built up for work under medical supervision, we might as well use the phrase to cover the phases of child guidance or education in which doctors, or other workers with individuals, may be able to contribute something of special value.

Doctors of medicine are an arrogant lot who have been regarded as wise and courageous so long, in all conventional and proper literature, that they automatically take the head of the procession if they are asked to the party at all. They

* Read before the Parents' Council of Philadelphia, The Institute of the Pennsylvania Hospital, March 7, 1932.

have associated so long with anxious parents, well-disciplined nurses, and helpless patients that they expect docility in the groups they control. Just now, in the mental-hygiene field, there are many bewildered medical men who are like the hen with the brood of ducklings. Parents, teachers, social workers, and so on are not only out from under the medical wings, but are doing an extraordinary number of interesting things in a more efficient way than the bewildered hen can conceive.

Without following this metaphor to an awkward conclusion, the situation is as follows: The medical man can do one of a number of things. He can feel that the vivid, well-informed parent or social worker who started with a medical technique and then pursued an interest beyond medicine is a foolish soul, who will necessarily suffer her just deserts. He can go a step further and regard her as a traitor. He can have all sorts of fun discoursing on the dangers of the lay public doing things with tools that only doctors understand.

If he is interested instead of dismayed by all the excitement, he can enter into the spirit of the game and see where he can help. The cards are all stacked in his favor if he cares to enter into the job of child guidance or education or of mental hygiene. No matter how little he knows about it, he is accepted as an advanced student.

To my mind it is a vividly interesting thing to enter this field. I believe fully that doctors who have not specialized in or who are not even thoroughly trained in mental medicine have a definite place in the educational team. Obviously, no one but a competent doctor can control the educational process when illness forces the school to stop work. Furthermore, no one else can tell the parents when, and on what terms, it is proper to let the school reënter into control.

The efficiency with which doctors manage illness depends to a very large extent on the accuracy of their ideas as to the cause and the course of the diseases they treat. Sometimes no questions arise. Surgical practice in childhood is almost perfectly managed from the educational point of view. A period of anxiety, a period of rest, and a period of perfect health follow with commendable regularity and great prompt-

ness. The child is returned to school without delay or disability and nobody is in any doubt about what to do next.

When anxiety is prolonged, when disability continues, or when capacity to carry on ordinary duties is doubtful, a very different set of influences is brought into play. Here the doctor's attitude is of very real importance. If a relatively common situation, like pneumonia with complications, is considered, it is easy to see how shifting emphasis and changing methods of management may be needed. During the first few days, acute illness forces every one to accept the silent, restrained routine of critical medical care. A period of lassitude follows, with every one ready to leave very well alone. Then, just as everything seems to be going well, pus accumulates and an operation is performed. Then comes a tedious convalescence, often lasting for weeks. The impulse of every one is to think of management in terms of rest. If the child is docile and allows people to do everything for him, great content exists among the numerous attendants, volunteer or professional. As long as a dressing must be changed daily, the invalid is king of the sick room. If he is at home, he can be a tyrant without trouble; if he is in a hospital ward, he is likely to find two equally effective methods of getting his way. He can be gay, in which case he is the pet of the nurses and doctors, or he can be plaintive. If he cries, no nurse is so hard-hearted as to leave him in distress. If he is of a belligerent habit, he finds that rowdiness is received with amusement. To all intents and purposes, he can do no wrong unless he keeps his temperature high or his weight low.

But sooner or later everybody thinks that it is time to release him from his bondage. His drainage tube is out, his charts are dully normal, and his lungs are clear. To the credit of childhood it may be said that a lot of children take the step back to normal living without a groan. With younger children, in whose case life exerts relatively little pressure, the convalescent is allowed to slip back into activity at his own pace. Among older children, things may not be so simple. The teacher is chiefly interested in seeing how much extra work can be imposed. The child comes home to find parents coöperating with the school by deprecating any effort

to work hard, while the doctor, with complete disregard of education, suggests that it makes no difference whether the child passes or not. Usually the whole pressure of every one is exerted upon the child without any very clear notion of what the child wants. This sudden shift from a human environment that prevents pressure to one that imposes it is an obvious source of trouble. The restlessness, the apathy, the headaches, the loss of appetite, or the fatigue of convalescence are by no means always based on repair of tissue or upon demonstrable physical disability.

The picture as drawn is obviously not the rule, but fragments of it occur in many cases where an illness of months is succeeded by complete physical recovery. The obvious solution is to arrange matters in a more logical way. The surgeon does well when he tells a child that he will be getting up on the eighth day, out of bed on the eleventh, and back home on the sixteenth, with lessons at home until the twenty-fourth. The physician in charge of uncertain illness cannot do this. Probably he cannot even look into the innumerable details of care required by a sick child. But he can foresee certain difficulties and attempt to influence the attitudes of the child and of those about him so that the abrupt transition from the omnipotence of illness to the relative helplessness of health can be softened.

On the whole most people are too busy to do very much permanent damage in the definite, ordinary, self-limited diseases, but doctors, nurses, and other participants in the care of the patient can do almost irreparable harm by their activities when they are faced by uncertainty.

Take, for instance, a child who during recovery from an acute illness has an abnormal sound in the heart. Perhaps no one can decide whether it is temporary or whether it indicates permanent damage to a heart valve. Here is a very interesting problem for the attending physician. The protection of the patient from strain during a period of observation must be assured. Most doctors these days tell the truth as they see it in season and out. Most parents ask for it. I have practiced pediatrics for years and I have all sorts of doubts as to heart murmurs. Most pediatricians are often in doubt. A few years ago the almost uniform advice by consultants under these circumstances was as follows: "Keep

the child in bed under medical care and protect him in every way from activity for so many days or weeks, and then let me reconsider. After that let me see him at intervals for a further period of months. Certainly do not let him indulge in any competitive sport for one or two years." This advice is not necessarily bad for the heart, but if nothing is thought or said of the psychological stresses set up, of the solicitudes established, of the social difficulties created, it is certain to be bad for the child.

Another type of problem arises when a routine is set up that involves frequent and unalterable visits to a doctor's office. I have almost come to the absurd point of believing that orthodontists and orthopedists, to mention only two of the most useful individuals in the work of child guidance, should employ visiting teachers and psychiatric social workers to supplement the services of the dental hygienists and the physiotherapists who control so much of the time of the children under their care. The inevitable emphasis on posture, on teeth, or on nutrition by physicians needs to be subjected to constant reappraisal by parents and by teachers. If doctors are correct in believing that all sorts of physical advantages are to be gained by constant supervision, they must necessarily consider the wide-flung social and psychological results of their attentions.

Finally, it is very dubious whether doctors do not need to be looked at with some suspicion on account of their inevitable habit of regarding abnormality as a disease. If, for example, a child has had infantile paralysis and now has a weak foot, they think of the child as having infantile paralysis and so label him both in their files and in their minds. The teacher knows better. The teacher is working cheerfully and effectively with the extensive physiological machinery that is still intact, while the doctor may still be gloomily pondering on anatomical details. Of course doctors aren't quite as bad as I make them out to be, but we can be pretty dangerous.

Obviously there are many phases of illness in which urgent reasons exist for enforcing absolute rest, for emphasizing symptoms, for encouraging watchfulness for trouble. Under such circumstances doctors may properly impose martial law and ride roughshod over the principles and practices of

mental hygiene, but when martial law is not urgent, it can obviously do harm.

It seems to me that discussions between parents, doctors, and teachers might well be held in which health and disease in the individual child would be considered from the point of view of family and school as well as the hospital. That any action upon such a suggestion may lead to all sorts of friction is obvious. The doctors must expect to flounder in educational quicksands; parents will be scolded when they want to be shown that three hours a week at the doctor's office is better than three hours on the playground; and teachers will possibly miss the rest that must be very comforting when children are kept out of school "the rest of the term."

But out of really vigorous controversy, we may get a team of child-guidance experts—parent, teacher, and doctor—none of whom claims exclusive authority or continuous leadership, but all of whom will watch intelligently and interfere reluctantly, but definitely if need arises. In theory at least, there need be no particular conflict. Each one will be ready for compromise and each will watch somewhat fearfully to see what the child thinks of him. Under such an arrangement the care of illness and convalescence will obviously be under medical supervision, but family and school also will watch their own interests in the child.

HABITS; THEIR FORMATION, THEIR VALUE, THEIR DANGER *

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IT would be of advantage, I think, to use the term habits in a much broader sense than we ordinarily do. I shall use it to include both the motor and the emotional responses of the individual, the sum total of habitual reactions through which the personality is expressed. Habits are nothing else than the individual himself.

For the purposes of this discussion, we can assume that the newborn infant is without habits, but begins to acquire habitual reactions very early in life—some say even before birth. However that may be, the individual develops habits in the process of growing up. These habits are dependent upon the environment and the experiences to which the individual has to adjust. There are, to be sure, certain inherent tendencies that manifest themselves at a very early age, but these so-called instinctive reactions are all modified by experience. We are told that the only two constant instinctive reactions that we have at birth are fear of losing our equilibrium—that is, fear of falling—and fear of noise.

An efficient, well-adjusted individual is one whose habits and mental attitudes toward life are so well organized and integrated that he is capable of making the essential compromises called for by the obstacles that he has to meet. The individual who is approaching his maximum efficiency and getting out of life the maximum amount of happiness is the individual who has acquired habits that work out to his or her advantage.

These habits represent a compromise between the instinctive drives of the individual and the barriers set up by society—and the most important part of society to the child

* Read before the Parents' Council of Philadelphia, The Institute of the Pennsylvania Hospital, February 8, 1932.

is his parents. So habits represent our ordinary responses to life.

We begin to acquire habits, then, at birth—habits of eating, sleeping, elimination. We develop habits or habitual responses toward various situations that arise very early in life—toward authority, for example; we acquire habitual reactions toward meeting the various barriers set up by parents; we acquire habitual reactions on a moral level, habitual reactions in the way of manners. And the efficiency of the habits we acquire depends upon the efficiency with which we fit into the social scheme of things. Mental habits, such as shyness, jealousy, fear, are just as much acquired as the habit of using a knife or a fork. The habit of delinquent behavior, such as lying and stealing, again are habitual responses that are acquired very early in life. As we see these habitual responses being developed in the individual, we can realize how necessary it is to keep in mind that his mental attitude toward the habit is important. We find that the various habitual responses on the moral level have a different value at various years. The child who steals at six years of age is quite a different problem from the child who steals at ten years. The child who steals at ten under impulsion, but who is remorseful and sorry, is quite different from the child who has an utter disregard for the delinquent act that he has carried out.

During the first six years of life, the child is confronted with environmental situations that bring about all the various emotional responses which may become habitual. In this period he comes into contact with environmental situations and individuals that bring out jealousy, cruelty, hatred, and feelings of inferiority. So these first six years of life are tremendously important in so far as the future of the individual is concerned, because in them he acquires the various tools or habits, the various emotional responses, that he will utilize in his later life.

There are several things to be considered in dealing with habits or with the development of personalities. In the first place there is the raw material, so to speak, with which we have to work in our effort to establish habits; there are the mental characteristics of the child at birth, of this individual

that we are going to nurture—nurture rather than try to mold—into desirable habits. The second thing we must ask ourselves is, What is the purpose behind the habit? Are the habits ends in themselves or are they simply means of attaining certain goals? And thirdly, how shall we determine what is the motivating force back of the habit, whether or not the habit be good or bad?

The first point, the material with which we have to deal, is of tremendous importance, I think. We as parents and teachers often forget this aspect of our problem. We forget the characteristic psychological urges back of the activity of the newborn child or the child during the first few months of life. In the first place, as MacCurdy puts it, "this individual is self-centered; it is self to be pleased, self to be praised, self to be saved, feared, and exalted on all sides." The child recognizes no obligations to society, and when he coöperates, it is simply a matter of expediency. The responses are invariably what we would call rather crude responses—fear and anger and joy, but joy usually from lust of power. There are none of the finer reactions or responses, such as love or sympathy and other of the finer emotions of that type. The child's responses to life are those of self-indulgence. All these instinctive reactions that I speak of are self-centered and purely ego reactions, their primary purpose being for the individual.

A little later on the child gets the conception of self; he begins to think of the real purpose that these ego reactions serve in his life and to consider how he can avoid unpleasant situations and attain pleasant situations. That is, he develops an idea of consciously conceived pleasure and pain; he begins to realize that he is in a social group and that certain types of conduct bring him pleasure, while other types are painful. And as he advances in years, these responses are no longer on a purely instinctive level, but he begins to appreciate intellectually that certain things are more desirable than others.

The next step is that in which the child builds up an ego ideal. He begins to think of himself as what he would like to be and what other people would like him to be, not what he is. But in building up this ego ideal, he begins to conceive

for himself a certain ideal or goal which he would like to attain. Out of his striving to attain this goal, ambition first makes itself manifest. Of course any ego ideal for the child or for the adult that does not incorporate standards of conduct that are approved by the social group will soon bring the individual into conflict with society. If this ego ideal does not incorporate standards approved in the family, on the playground, or at school, the child will find himself in conflict with the social group.

From the time the child is born, social pressure is brought to bear upon him to acquire certain modes of reaction that are approved by society. But to start with, the child is amoral and it is only through the process of training and education and experience that he will build up moral attitudes and adequate social responses, that he will build up a personality that will manifest itself in socially approved behavior and so will work out to his advantage. That is really what we mean by mental health. Mental health is but a state of mind—a state of mind that permits the individual to approach his maximum efficiency, to attain the greatest amount of happiness, and to do this with the minimum amount of friction. The child who has undesirable habits of eating or sleeping, or the child who is shy, is a child that is not enjoying good mental health. Bad habits are incompatible with good mental health.

This, then, is the material with which we start out—an egotistical, self-centered young beggar, if you will, striving for every opportunity to satisfy his own instincts, and parents who are striving to socialize this individual by training, experience, education, by setting up standards of the social group for the child to imitate. These things all children have in common, and another thing that is common to children is the goals that they are struggling to attain. There are certain goals in life with which children start out and which they struggle to reach. It is in the process of trying to attain these goals that certain undesirable habits, undesirable personality traits appear and that the personality itself becomes twisted and warped. Again MacCurdy makes this clear. I summarize from his book:

The first and earliest drive is the desire for food and drink,

for creature comforts and pleasant bodily sensations. The child struggles instinctively for these things before he really knows what he wants. He wants to be comforted, petted, handled, and he struggles for these pleasant bodily sensations and all that goes with them. In the process of acquiring these things, in getting food and drink, the child may become over-conscious of parent and may get a fixation on parents, which he may have difficulty in getting rid of later. He looks on the mother as the source from whence all blessings flow and his attention is primarily directed toward her because she is the one who helps him to attain his desired goal.

Intellectual curiosity is another desire that children are always trying to satisfy. In the attempt to satisfy this inherent drive, certain problems arise—undesirable habits, destructiveness, truancy, and the like. It is the child who is curious who vanishes around the corner or skips a couple of blocks and gets on a truck or runs off at a very early age. It is not uncommon to find children of five in the truant class. Again, a child may be destructive in the eyes of his parents, while his activity is very constructive so far as he himself is concerned. He wants to investigate, and he has to learn, in the process of growing up and encountering the barriers set up by parents, that this cannot always be done. It is desirable not to inhibit this intellectual curiosity, but to turn it into the right channels.

The lust for power is another desire. Children not only want power, but demand the opportunity of exhibiting, of demonstrating that power. We see this in some of the simplest problems with which parents have to deal. Take the meal hour, for example. It is not at all uncommon for the child to utilize his meal time to exert his influence over the parents. It is not uncommon to hear a parent say that the nurse, the maid, and everybody else have been trying in vain for the past few weeks to make her child eat. The child knows that the mother will threaten him, bribe him, tease him, coax him, and will let the maid or the older sister do the same. All he has to do is sit back and demonstrate the fact that he will not eat, and after the mother gets through the coaxing and teasing, she will feed him. It gives the child the opportunity to demonstrate his power over this group of adult individuals.

The desire for recognition, the demand for attention is another goal. It is closely allied to the lust for power, but you see it as the child grows up and wants to be the show-off. Sometimes the child uses temper tantrums as a means of getting attention. Such children are nonconformists. In the process of growing up they get away from temper tantrums and begin to use other habitual methods of getting attention. A nonconformer is an individual who has been unable to get attention in a social way and so gets it in an asocial way.

The desire for security is another goal. Children, of course, are concerned about their security only as it is threatened. We as adults are more concerned about our security before we lose it. We have learned from experience and training that it is the part of wisdom to consider our security before we lose it. If we contemplate doing something that we question, we immediately begin to think that our friends or neighbors or superiors may question it. We ask, Suppose we do this, who is going to know it, and if they do, what difference will it make? That is, our security oftentimes depends upon what we think society is going to think of us. We have a fine ability to discriminate between what we think is right and what society thinks is right, and we feel that it is the better part of wisdom not to offend the social group. The child usually does not become concerned about security until he loses it, but there are children who become too much concerned about security and about pleasing mother and father and everybody else. They lose the initiative that is so important in the development of a personality or an individual and for which we all respect an individual.

So the goals that we find the child struggling to attain are, after all, pretty much the same goals that we as adults go through life trying to achieve. We are concerned about our physical comforts; we are concerned about our power; we are concerned about exerting influence upon some particular group, in the community either of the home or of the state; the desire for attention modifies our activities. We acquire attention in various sorts of ways, but we have learned that the way in which the child instinctively demands it is perhaps the best way for the adult to lose it, so we get it in more subtle ways. So, too, the desire for security is with most

of us—that is, we think in terms of the future, not only our own future, but the future of our families, of our children, and we seek the means and the habits to enjoy a bit of security in the material things of life.

It is the methods that we use to attain these goals that change. We learn to seek them in ways that are socially approved. In other words, the instinctive method that the eighteen-months-old baby utilizes is not satisfactory to the eight-year-old child or to the eighteen-year-old adolescent. They have to be modified to meet the demands of the social group.

During the first decade or perhaps the first six years, there are certain mental characteristics that we can utilize in altering habits. Children at this stage of development are more suggestible; they accept without adequate grounds for accepting that which comes from those in whom they have confidence. This prestige of suggestion is very important. The child is more imitative also; he imitates not only what he sees and hears, but to a large extent the mental attitudes of the parents, their mannerisms. The whole mental atmosphere of the home is often shown in the personality of the child. Plasticity, too, is very much more marked in early life; in fact, the older most of us get, the less plasticity we have. The ability to make new adjustments, to fit into new situations, to take on new habits and give up old habits is characteristic of early life. We all must retain a certain amount of plasticity in order to fit into the social scheme of things, but in children it is more marked than with adolescents and with adolescents it is more marked than with the adult.

I like to reduce habit and behavior to rather simple terms. Behavior is complicated, but it can be reduced to simple terms if you think of conduct as the reaction of the individual to his environment. It does not make much difference whether it is the conduct of an individual in the state prison or a child in the nursery; it is still the reaction of the individual to his or her environment.

If we are going to understand conduct or behavior, there are several things we must remember. The first thing to keep in mind about habits is that conduct itself is but a guidepost—it directs us back to the goal; and the important thing behind conduct, which is made up of habits, is really

the motive, just as the important thing back of a headache is not the headache itself, but the eye strain or the brain tumor or the high blood pressure—the something that is producing that headache. Socially, conduct is tremendously important. We judge our friends, neighbors, and children—and they judge us—by conduct. But psychologically it is the motive behind the conduct that is important. We may have three or four different children coming into a clinic in a morning, all of whom are reported by their parents to be stealing. Socially they are thieves, they are stealing; but as we study these individuals, we will find that the motives back of the stealing may be four entirely different motives, four entirely different causes that will call for quite different methods of treatment.

Another thing to keep in mind about conduct is that it must always be interpreted in terms of the individual's past experiences. Stealing, lying, shyness, jealousy, or personality deviations of a more serious nature, whether tics, mannerisms, or something of a physical nature—all these symptoms must be interpreted in terms of the experiences the child has been through, the emotional situations that he has encountered, the personalities of his parents, in brief, the past history of that particular child. As parents, it is the conduct that annoys and humiliates and causes inconvenience about which we are most concerned. But often the conduct that causes us most concern is not, after all, the most important in the life of the child. That is, if the child is busy, hyperactive, and mischievous, and in constant contact with his environment, he is likely to get into social difficulty; but it may be the shy individual who is commended for good behavior and desirable attitudes toward life—the child who is afraid to make contact with his environment, who is getting too much satisfaction out of a sense of security in relation to his family—who will eventually be the real problem. The extraverted individual has the opportunity of becoming socialized by the fact that he is making contact with a group that is setting social standards. It is the child who is withdrawing from life and is commended for so doing who is in real danger of not being socialized by his environment.

We must, then, keep in mind that behind habits and mental responses are certain satisfactions that the individual is de-

riving from this behavior and we must see that the unsatisfactory conduct is supplanted by another type of conduct that will be satisfactory to the individual and at the same time socially acceptable. For example, there is the child who steals money from his mother, buys candy, stuffs it in his pocket, and goes up to the playground. The motive behind this asocial activity happens to be that this boy is not acceptable to the group because he does not participate in their activities as his older brother does, but he can buy his way in; so he resorts to stealing as a means to an end, bucking up his own self-esteem. The reason is quite obvious. It is not going to do any good to see that this boy is simply prevented from stealing by not having the opportunity to steal. It is useless to think that anything constructive has been accomplished until we have done something to help him win the satisfaction of acceptance by the group by some other method than buying it.

The environment is made up of many factors, whether you are dealing with your own child, your neighbors' children, or children in a clinic. The social, cultural, intellectual, religious, and racial backgrounds are of great importance in our effort to understand conduct and habits. You will find that in certain races children become very subservient to authority and may develop an authority complex; they may grow up resentful and rebellious to authority. Again, economic situations may cause conflicts in the lives of children. For example, a janitor's children may have a difficult time because they do not enjoy the same social status as other children in their group; they are made to feel that they are outcasts by nurses and parents. These are important experiences to the child and are very closely connected with the complications of social life.

People are the most important factors in the lives of children, and the most important people are parents. I can just mention in passing that a great many of the conflicts and undesirable habits and traits of children are brought about by the fact that children have to live with parents who are suffering from mental indigestion. Parents who have not solved their own problems, who are unhappy, who are dissatisfied and discontented, invariably create for their children an environment that gives rise to many problems. There are

children who would be problems in any environment, the constitutionally inadequate children. Again, there are certain phases through which children pass in which problems are to be expected. But the great majority of problem children are showing symptoms of a poor environment, reacting to an undesirable situation. You cannot expect a normal child to respond to an abnormal environment without a reaction that we as adults are going to look upon as asocial. They are going to devise modes of meeting that situation which are undesirable, socially disapproved, but which, after all, are but normal responses to that particular situation.

In an effort to overcome undesirable habits, it is necessary to study the child to find out what these habits mean in the life of the individual. You will find that they serve a purpose, and that the satisfaction that the child is getting out of a bit of undesirable conduct can frequently be attained in a way that is socially approved. The child who is a bully, for example, may get as much satisfaction from being a protector. We must do more than stop the undesirable habit; we must substitute something in its place.

One may ask why this is so important. It is important for this reason: We who are in the practice of medicine see a very large group of individuals—probably representing 50 per cent of all the people in the out-patient clinics and 50 per cent of all those who come to our private offices—who are sick, but when we try to interpret their incapacities, their failures, in terms of the laboratory or of the clinic, we are met with defeat. We see Mrs. Jones; her heart, liver, lungs, and kidneys are all right, yet she cannot look after her children, she has headaches, backaches, cannot drive a car, is totally incapacitated for meeting her obligations as a wife and mother or as a neighbor. Yet we, as physicians, with all our refined technique, are unable to interpret her incapacities in medical or clinical terms. Invariably we find that Mrs. Jones is an individual who has not grown up. She is an individual who is utilizing the same habits at twenty or twenty-five as she was at the age of six or eight; she is an individual who is intellectually intact and physically all right, but who is still living on a very low emotional level. She is still meeting her problems in a way in which you might expect her child of eight to do. She has found illness a

retreat. She has found a subtle way of getting attention. She would find it incompatible with her ideals to have temper tantrums, but unconsciously she has found another way of getting attention. The great majority of neurotic individuals are individuals who are utilizing infantile habits and early reactions to meet their adult responsibilities. It is tremendously important to keep in mind that as the child advances in years and receives new opportunities and privileges, at the same time his responsibilities and obligations to the family, to his schoolmates, and to others should be increased. There is a very strong feeling in most of us of not wanting to see our children grow up. We get so much satisfaction in doing for our children that we deprive them of the opportunity of being what nature really intended them to be—reliable and efficient at a fairly early age. We make them struggle too hard for their independence, so that many of them are crippled emotionally in the battle.

BUMKE'S CRITIQUE OF PSYCHOANALYSIS *

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AS one who has for years been deeply interested in the treatment of mental disease and the preservation of mental health, I have been much gratified by the interest the mental-hygiene movement has awakened among the laity and among professional psychologists and psychiatrists. But no doctrines, however alluring, should be adopted unless they are supported by ascertained facts and by logical reasoning, and there is a special need for such caution in the field of mental hygiene. If it were solely a matter of protecting the mental health of the public, we might be less concerned about the outcome of this movement, since neurologists and psychiatrists as a group would probably give sober advice; but mental hygiene, by and large, will have a very distinct influence upon the mental and moral development of our youth.

Teachers, parents, and physicians have a great responsibility in developing the characters of our future citizens. For this reason it is vitally important that teachers and parents, as well as the "mental hygienists" in charge of our child-guidance clinics, shall have the soundest and most carefully tested information that we can give them. I fear that psychoanalytic doctrine has done much mischief in this direction because of the excessive and unwarranted stress laid upon sex doctrines, to the neglect of other factors that are far more important in the development of character, but that do not receive the attention due them.

It is the sex appeal of Freudian doctrines that has given psychoanalytical writings their great vogue among literary and professional groups. Let Freud put forth a theory—and many of his theories are interesting and ingenious—and the average disciple accepts it as fact and then presumes to

* *Die Psychoanalyse, Eine Kritik*, by Oswald Bumke. Berlin: Verlag Julius Springer, 1931.

base his further argument upon such "facts." As McDougall has said, "The emotional fervor engendered in Freud's disciples by his glowing and dramatic descriptions of the villainy of 'the Unconscious' seems to paralyze their critical faculty."[1] And Strümpell has spoken of the "exaggeration of the so-called psychoanalytic school which affords its devotees a playground on which to display minds that have a fertile fantasy, but no critical faculty, that hide a confusion of thought behind a mask of specially devised words and concepts."[2]

Physicians, including neurologists and psychiatrists, have allowed many of these doctrines to go unchallenged. A few men have raised their voices, pleading for calm judgment, granting that many of these new theories—on the subconscious, the Œdipus complex, the symbolism of dreams, the libido, and what not—are ingenious, but insisting that the test of logic be applied to them. Of course, the instant the psychoanalyst concedes that he is no longer presenting facts in a logical way, he thereby excludes himself from the ranks of scientific investigators.

Alexander's article, *Psychoanalysis and Medicine*,[3] in a recent number of this journal, has suggested the propriety of asking the followers of this mental-hygiene movement to listen to another man of highest repute, who, in a very thorough and painstaking study, has stated some of the reasons why many of us cannot accept these teachings of the Freudian school as blindly as his disciples do.

Oswald Bumke, of Munich, is one of the foremost psychiatrists of Europe, a man of great distinction, a thoroughly sound scholar, a brilliant teacher, who succeeded Flechsig years ago and now holds the chair once occupied by Kraepelin, whose influence on modern psychiatry not even a Freudian will have the right to question. The present writer has had his say during the past six years[4] and so have others

[1] *Outline of Abnormal Psychology*, by William McDougall, M.D. New York: Charles Scribner's Sons, 1926.

[2] Strümpbell. *Deutsche Zeitschr. für Nervenheilk.*, Vol. 31, 1924. p. 67.

[3] MENTAL HYGIENE, Vol. 16, pp. 63–84, January, 1932.

[4] See *The Normal Child and How to Keep It Normal in Mind and Morals*, by Bernard Sachs, M.D. (New York: Paul B. Hoeber, 1926.) See also Chapter XXXI of *Mental and Nervous Disorders from Birth Through Adolescence*, by Bernard Sachs, M.D. and L. Hausman, M.D. New York: Paul B. Hoeber, 1926.

here in these United States. I need only mention the names of Dana, Peterson, Kennedy, Walsh, Mills, Hollingworth, Jastrow, Burnham, Mrs. Ladd Franklin, McDougall. And further opportunity will no doubt be given to reveal the very questionable relation between Freudian theory and the practice of medicine; but this aspect of the subject must be presented before another forum.

In this article, it will be my chief purpose to present Bumke's views, selecting the more important topics. In order to do full justice to this author's carefully elaborated opinions, I shall quote and translate freely (not always verbatim, but, I trust, correctly) from his brochure of seventy-five pages, which appeared in 1931.[1] It is evident that Bumke undertook this trying task from a sense of duty and an appreciation of scientific truth.

After a very happy introduction, he takes up Freud's statement that unless his opponents will concede the premises of psychoanalysis, he (Freud) cannot discuss the subject with them. In this statement Freud himself unintentionally raises the question whether psychoanalysis is a science, since, Bumke asks, do not the same laws of logic apply to all scientific doctrines? He continues:

> "I have opposed psychoanalysis for almost a generation. I consider Freud one of the most important thinkers of the last decades, and I know that while reading his writings, I am in the presence of an unusually brilliant and original mind. I acknowledge that we are indebted to him for many valuable revelations, that my own views on the many contradictions of the human psyche have been modified by a critical study of psychoanalytic writings; but I must reject his doctrines. And more than to the content of his doctrines, I object to his method, because it is diametrically opposed to my conception of exact scientific investigation."[2]

Bumke then devotes several pages to the completely contradictory impressions of psychoanalysis held by such men as Allers, Kronfeld, Straus, and Bumke himself, on the one hand, and Thomas Mann on the other, the former group opposing psychoanalysis because of its materialistic views of the psyche and its efforts to rationalize the unconscious, while Mann feels that Freud's doctrine of the libido is natural

[1] Some younger mental hygienist might find it worth while to publish a complete and readable translation.

[2] *Die Psychoanalyse*, p. 5.

science turned into romance, and that psychoanalysis is a reaction against the mechanistic and materialistic tendencies of the last century and a form of modern irrationalism. In Bumke's opinion these contradictory impressions of psychoanalysis are due to the fact that psychoanalytic doctrines are self-contradictory, possibly because, as Michaelis[1] and Maylan[2] have tried to show, they spring from conflicts in Freud's own nature.

In attempting to gauge the merits and the evils of psychoanalysis several years ago, the present writer selected a number of special topics which he considered to be the pillars of the psychoanalytic edifice; the temple was to stand or fall by the carrying power of these pillars. I am glad to see that Bumke has adopted the same method of discussion and has selected the very subjects I fastened upon:

> "You may define science as you please. *Psychoanalysis is not natural science nor any kind of science,* nor is it a fairy tale. For unlike the latter, it does not spring from the heart, but rather from a coldly brooding and yet misguided intellect.
>
> "What is Freud's 'unconscious'? A gnome working in the dark, but not so amiable nor so kind as the little man of the fairy tale; an inferior psyche, which operates with the feeling and intellect of the superpsyche, handing over to consciousness only the finished product; a kitchen in the cellar in which the daintiest dishes are prepared to be put on the dumb-waiter and served upstairs; the real ego, that thinks, feels and wills, desires and rejects, hates and loves, but above all is always amorous and passionate, that not only lies to and deceives others, but is constantly deceiving its own consciousness and to that end must engage in all sorts of complicated deliberations—and yet that is nothing more than brain activity subject to the laws of mere energy.
>
> "But what we call consciousness is a poor devil who thinks he is pushing when he is really being pushed; 'an occasional isolated act'; 'a part'; not really the psyche, but merely a sense organ that can 'perceive' psychic attributes. Consciousness reveals only a section of the psyche, and at that a false and distorted section that cannot be interpreted without deciphering the mystic writing behind which the unconscious, the id, the real soul, hides itself. In consciousness great contradictions exist side by side; in the unconscious there is nothing of the sort. Deeper psychoanalytic insight will reveal to you that what

[1] *Die Menschheitsproblematik der Freudschen Psychoanalyse, Urbild und Maske,* by Edgar Michaelis. Leipzig: Verlag J. A. Barth, 1925.

[2] *Freud's Tragischer Komplex: Eine Analyse der Psychoanalyse,* by Charles Maylan. (Munich: Verlag Ernst Reinhard, 1929.) This analysis is important and illuminating, but having known Freud in his student days, I cannot accept Maylan's opinion that Freud's views are due to an inferiority complex and to feelings of hatred and revenge.—Sachs.

appears to be innocent, indifferent, accidental, or what is apparently absurd, is in reality well planned, purposive, important, and necessary."[1]

So much for the unconscious. How about Freud's libido? On this point Bumke quotes Freud's own words:

"Libido, analogous to hunger, is the force through which the instinct, here the sex instinct (as in the case of hunger it is the instinct to eat) expresses itself. . . . We observe that the suckling wishes to repeat the act of taking in food without actually demanding more food. . . . We say he is 'sucking' . . . The gratification can only be attributed to the excitation of the mouth and lips; hence we call these parts of the body *erogenous zones* and the pleasure derived from sucking *sexual*. . . . The sucking at the mother's breast becomes the term of departure for all of sexual life, the unattained ideal of later sex gratification."[2]

"Analysis shows that in these symptoms [those of hysteria] there are expressed all those tendencies termed perverse, which seek to represent the genitals through other organs. . . . Through the study of hysteric symptoms we have come to the conclusion that aside from their functional activities, the organs of the body have a sexual significance. . . . Countless sensations and innervations, which are symptomatic of hysteria, in organs apparently not concerned with sexuality, are thus discovered as bound up with the fulfillment of perverse sexual desires through the transference of sex instincts to other organs."[3]

"But since all human beings have such perverse, incestuous, and murderous dreams, and not the neurotics alone, we may conclude that even those who are normal have passed through the same evolutionary development, through the perversions and the direction of the libido towards the objects of the Œdipus complex."[4]

"We have expanded the conception of sexual to include the sexual life of children and of perverse persons. . . . Outside of psychoanalysis sexuality means only a very limited thing: normal sexual life in the service of reproduction."[5]

"Slowly we familiarized ourselves with the idea that the libido, which we find attached to certain objects . . . may also forsake them and put in their place the person's own ego. . . . The name for this placing of the libido—narcism—was borrowed from one of the perversions. . . . In it the grown individual lavishes upon his own body all the affection usually devoted to some foreign sex object. . . . It is probable that . . . this narcism is the general and original condition out of which the love for an object later develops . . . and

[1] *Die Psychoanalyse*, pp. 16–17.

[2] *A General Introduction to Psychoanalysis*, by Sigmund Freud. Authorized translation. New York: Boni and Liveright, 1920. pp. 270–71.

[3] *Ibid.*, pp. 266–67.

[4] *Ibid.*, p. 293.

[5] *Ibid.*, pp. 275–76.

so auto-eroticism was the sexual activity of the narcistic stage in the placing of the libido. . . . Narcism is the libidinous complement of egoism."[1]

"Furthermore, we must take into consideration that the impulses of the sex instinct are extraordinarily *plastic*. . . . One thing may take the place of another. . . . The component impulses of sexuality . . . show a marked ability to change their object, to exchange it for another. . . . Among these processes which resist the ill effects of abstinence, one in particular has won cultural significance. Sexual desire relinquishes either its goal of partial gratification of desire, or the goal of desire toward reproduction, and adopts another aim, genetically related to the abandoned one, save that it is no longer sexual, but must be termed social. This process is called 'sublimation.'"[2]

Leaving aside all this romancing and juggling with the term libido, Bumke begins his critique "where Freud began his libido theory"—with the psychoneuroses.

Freud has stated that "all psychoneurotics are persons with strongly marked perverse tendencies which have been repressed in the course of their development and have become unconscious."[3] So thought Freud in 1905. Bumke continues: In the meantime the World War has produced numerous neuroses which most physicians have ascribed to causes quite other than sexuality. How does Freud meet this objection in 1925? To the contention that the war neuroses proved that it was unnecessary to harp upon sexual factors in the causation of nervous diseases, Freud answers:

"On the one hand, no one had been able to carry out a thorough 'analysis' of a case of a war neurosis, so that in fact nothing whatever was known for certain as to their motivation. . . . On the other hand, psychoanalysis had long before arrived at the conception of narcissism and of a narcissistic neurosis, in which the subject's libido is attached to his own ego instead of to an object."[4]

But, Bumke points out, in 1919 Freud maintained:

"The war neuroses . . . are to be regarded as traumatic neuroses, whose existence has been rendered possible or prevented through an ego conflict. . . . The conflict takes place between the old ego of peace

[1] *A General Introduction to Psychoanalysis*, pp. 359–60.

[2] *Ibid.*, pp. 299–300.

[3] *Fragment of an Analysis of a Case of Hysteria*, in *Collected Papers*, by Sigmund Freud. Authorized translation. London: The International Psychoanalytic Press, 1929. Vol. 3, p. 52.

[4] *An Autobiographical Study*, by Sigmund Freud. Translated by James Strachey. In *The Problem of Lay Analyses*. New York: Brentano's, 1927. pp. 285–86.

> time and the new war-ego of the soldier, and becomes acute as soon as the peace-ego is faced with the danger of being killed through the risky undertakings of his newly formed parasitical double. As one might put it, the old ego protects itself from the danger to life by flight into the traumatic neurosis in defending itself against the new ego which it recognizes as threatening its life."[1]

Bumke very properly remarks that this idea is not so new. The spirit is willing; the flesh is weak. But Freud goes on juggling with the terms libido and narcism at his own sweet pleasure. To quote further from Bumke:

> "Even if these terms have no erotic flavor, they retain the idea of sexuality. Does sexuality, whether it be synonymous with genitality or not, play a rôle in the war neuroses or does it not? Or, to use Freud's own words, did or did not those afflicted with 'war tremors,' for example, suffer from perverse tendencies that had been repressed and consigned to the subconscious? I know it is unfriendly to ask such a question. If you attack any one pillar, the entire structure crumbles."[2]

But such trifling matters do not disturb the great prophet and his followers. Freud says (1919): "If the—up to the present superficial—investigation of war neuroses has not shown that the sexual theory of the neuroses is correct, that is quite another matter from showing that this theory is incorrect."[3]

Bumke asks whether it is not in order to expect positive proof that a theory is correct instead of merely negative proof that it has not been shown to be incorrect. He brings up this point again in relation to Freud's theory that all fear and anxiety can be traced back to the anxiety experienced during the birth process as a result of the toxic condition produced by the cutting off of the supply of oxygen from the blood.[4] "Nowhere," says Bumke, "can I find the slightest proof of this theory."

> "In my opinion," Bumke continues, "Freud has from the start become so completely ensnarled in a certain conception of human beings—not only the abnormal, but the normal as well—that he is incapable of finding any but the one meaning in everything. In dreams, in slips of the tongue or of the pen, in the forgetting of dates, in innumerable apparently innocent actions, in ordinary conversation, and

[1] *Psychoanalysis and the War Neuroses*, by Dr. S. Ferenczi and others, with an Introduction by Professor Sigmund Freud. London: International Psychoanalytic Press, 1921. pp. 2–3.

[2] *Die Psychoanalyse*, p. 24.

[3] *Psychoanalysis and the War Neuroses*, p. 2.

[4] *Die Psychoanalyse*, p. 25.

> most of all in the free-association experiment of the psychoanalyst, the individual reveals sexual or other disappointments, unfulfilled erotic desires, painful memories, hidden intentions—in short, a thousand motivations of which consciousness, the real ego, is not directly informed. The same sexual impulses which, when suppressed, cause the neuroses . . . may be 'sublimated'—*i.e.*, diverted from their primary purpose, in order that they may participate in the highest cultural and social achievements.''[1]

A similar idea has been expressed by others, but that these everyday errors common to all have a mysterious meaning, that they are always closely linked to the subconscious, the psychoanalyst might be expected to prove. We need not give in detail the many examples that Bumke quotes from Freud of slips of the tongue and of the pen and Freud's interpretations of them. They lose their point in translation. Bumke concedes that slips of the tongue or of the pen may now and then reveal one's innermost thoughts, but he denies, as the present writer did years ago, that the analyst has the right to generalize or to give a sexual twist to every occurrence. As an instance of this, he quotes the case cited by Freud of a young girl about to be analyzed, who hastily pulls down the edge of her skirt to cover a protruding ankle. ''She has,'' states Freud, ''betrayed the kernel of what analysis will discover later, her narcissistic pride in her bodily beauty and her tendencies to exhibitionism.''[2]

Freud's pupils allow nothing to pass unnoticed. Let no one, warns Bumke, however innocent, sitting at table or at a desk opposite a psychoanalyst, toy with any object. Let him fuss with his cravat or dip the pen into the inkstand, and the analyst will guess the true significance of his acts.

Whatever else you may do, beware of slips of the pen and of the tongue.

> ''A young woman signs her maiden name to a document. Later on her married life terminates unhappily. Freud concludes that the unconscious knew this at the time she made the slip of the pen. A lady asks the physician about a mutual acquaintance, mentioning her maiden name because she had forgotten the husband's name. She does not like the man—for that reason, says Freud, she has forgotten the name.''[3]

[1] *Die Psychoanalyse*, pp. 25-26.

[2] *Further Recommendations in the Technique of Psychoanalysis*, in *Collected Papers*, Vol. 2, p. 359.

[3] *Die Psychoanalyse*, p. 29.

Let each case be judged on its merits, is Bumke's position:

> "If any one maintains that he meant to keep his promise, but soon thereafter forgot all about it, I believe that he lies. . . . If a young woman has signed her maiden name to letters for twenty years or more before marriage and happens to sign that name once after marriage, or if a young husband loses his wedding ring, I am unsophisticated enough not to make much of it. At least it would be fair to put a control question: Have not happily married women signed their maiden names or lost a wedding ring? Of the thousands of German divorcées of the past decade how many have lost wedding rings?"[1]
>
> "I do distinguish," says Bumke, "between the ego and the id. The id, to my way of thinking, is the body, and as for the ego, I would look for extenuating conditions to account for forgetfulness and inattention. I consider Freud's conclusions altogether absurd. What evidence has he that actions which I consider entirely harmless are to be interpreted as suggesting masturbation, exhibitionism, or worse? . . .
>
> "Freud and his pupils state that we, their opponents, deny not alone their conclusions,[2] but also the *facts* that analysis has revealed. Nothing of the sort. I believe, for instance, the story of the bag and the ring. I believe that the babe sucks at its mother's breast. . . . I believe, in fact, even more than that—I believe as Mephistopheles did, that 'healthy babes feed *with pleasure*' . . . But I do not label these pleasure sensations of the suckling babe 'sexual.'"[3]

The ego and the id are annoying to Bumke as they are to many others.[4] He does not care to divide the individual in this way. He quotes from Freud: "It is . . . . very probable that the dreamer does know what his dream means, but does *not know that he knows and therefore believes he does not know.*"[5] "It is plain," says Bumke, "that the ego that knows is not synonymous with the ego that does not know that it knows. Proof must be given—that would be the Alpha and Omega of psychoanalysis—that two such egos abide in one and the same individual."[6] And if such proof is not forthcoming, all else is left dangling in the air.

[1] *Die Psychoanalyse*, p. 30.

[2] "Moreover the Freudians claim that their doctrines are misunderstood. . . . Failure to understand is possible, because our Freudian friends, both in English and in German, have managed to disguise their theories in a mass of verbiage which it is difficult for any one to grasp who may have a full knowledge of the language, but has, in addition, a wholesome respect for logical reasoning." Sachs, *loc. cit.*, p. 73.

[3] *Die Psychoanalyse*, pp. 30–31.

[4] "The ego is assigned a triple rôle in dreaming. . . . Surely it is a strange Protean Ego that acts in these three distinct capacities in the dream and at the same time." McDougall, *loc. cit.*, p. 172.

[5] *A General Introduction to Psychoanalysis*, p. 79.

[6] *Die Psychoanalyse*, p. 32.

In his further discussion along these lines, Bumke reverts to Freud's early experience at Bernheim's Clinic at Nancy and cites his interpretation of hypnotic suggestion. To the latter-day psychoanalyst, it is well-nigh an insult to hint that there is much of suggestion in their method and technique, and yet in his earlier writings, Freud was not able to throw aside Bernheim's teachings. Bumke's comments are of interest:

> "Hypnotism is a fine form of therapy; but if a physician wishes to find out anything about his patients, it is a dangerous method. In this field, as in that of hysteria, there has been so much error, suggestion, deception, and hocus-pocus, that it is hard to know what has really taken place and what the subject for one reason or another wanted us to believe. Freud, moreover, could very easily prove whatever was susceptible of proof without resorting to hypnotism. There are no memories that are not at times inaccessible, while at other times, they can be revived with or without aid. Every judge knows that, and every examiner has at times said, 'Think of this and that, and it will come back to you.' No one denies that there is latent knowledge. What I deny, or at least regard as not proved, is that these memories in the interim enjoy some sort of psychic existence, that they give rise to reflection, that they motivate action—in short, that they have the same effect as if they were conscious and not unconscious."[1]

Freud has evidently felt that it is not so easy to explain the active force of the unconscious; experiences are not forgotten, they are "repressed." There is no denying this repression, but Bumke takes this common-sense view of it:

> "We do not care to recall things that trouble us, of which we are ashamed, and which we would like to eliminate from our consciousness. We might not be able to go on living if we had to go on thinking of everything that is painful to think of, that makes life miserable. We try to get rid of such thoughts. . . . On the other hand, there are lots of things we have not had reason to think of for years and years—words and names, experiences of long ago that have little chance of being revived into consciousness without some special effort or reminder. Dates, names, a foreign language, mathematical formulæ, we are apt to forget. Unfortunately, painful memories are revived all too easily if some person or some event reminds us of them. Not the unconscious, but we ourselves, can recall them so soon as we wish to do so. We cannot help reviving them if anything excites these memories."[2]

Bumke is of the same opinion as the present writer[3] and many others that Freud and his disciples have made much

[1] *Die Psychoanalyse*, p. 33.
[2] *Ibid.*, pp. 34–35.
[3] Sachs, *loc. cit.*, p. 80.

of the interpretation of dreams and that in this their minds have run riot. Bumke thinks that the "censor" postulated by Freud is a sort of Cerberus, an extremely fanciful creation. Even in the dream this special authority is anxious to prevent repressed thoughts from passing undisguised into consciousness. The psychoanalyst maintains[1] that sleep proves that the poor human who came unwillingly into this world cannot endure it without interruption and for that reason retires now and again into the "warm, dark, non-irritating existence he enjoyed while in his mother's womb." There is to be no psychic activity during sleep, and if there be any, then we fail to regain the pleasure of fetal life. Therefore, such vestiges of psychic activity as persist are disguised by the censor and enter the mind as dreams. All of which has a very poetic quality, but does it really mean anything more than that in a dream the mind is not wholly at rest?

According to Freud, every dream has "a meaning all its own," but consciousness cannot get at it without the aid of psychoanalysis. In the dream,[2] symbolism plays its part, presenting what the subconscious really thinks and remaining under the control of the "censor."

> "Do not for a moment think," says Bumke, "that I have invented this term in order to achieve a *reductio ad absurdum*. Freud really means that in the dream a special and very complex bit of work is done in order to keep the consciousness in ignorance of the true instincts, thoughts, feelings, wishes, and aims of the unconscious."[3]

Bumke then relates several dreams in Freud's own words, to convey to the reader the absurd and fantastic lengths to which Freud goes in his interpretations.

In abbreviated fashion, one of these dream analyses may be given. The dream is quoted by Bumke in Freud's own words,[4] as related to him by the patient, a woman:

> "I was walking about in a town which I did not know. I saw streets and squares which were strange to me. Then I came into a house where I lived, went to my room, and found a letter from Mother lying there.

[1] *A General Introduction to Psychoanalysis*, pp. 67–68.

[2] Another thoroughly rational writer cautions against Freud's symbolism: "It is so largely the arbitrary interpretation of the examiner that it is beyond the pale of scientific psychology." (Robert Bing, in *Lehrbuch der Nervenkrankh.*, 4th ed., 1932. p. 524.)

[3] *Die Psychoanalyse*, p. 36.

[4] *Fragment of an Analysis of a Case of Hysteria*, p. 114.

> She wrote saying that as I had left home without my parents' knowledge, she had not wished to write to me to say that Father was ill. 'Now he is dead and if you like, you can come.' I then went to the station (*Bahnhof*) and asked about a hundred times, 'Where is the station?' I always got the answer: 'Five minutes.' I then saw a thick wood before me which I went into, and there I asked a man whom I met. He said to me, 'Two and a half hours more.' He offered to accompany me. But I refused and went alone. I saw the station in front of me, but could not reach it. At the same time I had the usual feeling of anxiety that one has in dreams when one cannot move forward. Then I was at home. I must have been traveling in the meantime, but I know nothing about that. I walked into the porter's lodge and inquired for our flat. The maid servant opened the door to me and replied that Mother and the others were already at the cemetery (*Friedhof*)."

During the conversation, Freud is told that at Christmas the patient received an album with views of the city and kept it in a box, but for a time could not find the box. Furthermore, the young lady had sat in Dresden for two hours in front of the Sistine Madonna (Freud adds, the *"Virgin"* Mother). Finally, during the evening before the dream, in order to get a cognac for her father, she had asked her mother five times (not a hundred times, Freud observes) for a key.

> "Freud concludes," Bumke continues,[1] "that the station in the dream represents the box. Moreover, the question, 'Where is the *key*?' seems to be the masculine counterpart to the question, 'Where is the box?' They are, therefore, questions referring to—the genitals. The third conclusion is that the death of the father means that the dream contains a revenge phantasy against the father. 'The sympathetic feelings of the day before' (for the father, who had not been well that evening) 'would fit in with this.'"

Moreover, Bumke goes on, a short time before, the patient unfortunately had seen in the "Secession" exhibition a painting of a dense forest, with nymphs in the background. That settles it. The picture (forest, nymphs) means woman (*Weibsbild*, a derogatory term). "At this point," Freud continues, "a certain suspicion of mine became a certainty."[2] The station, serving purposes of *Verkehr* (intercourse), the cemetery (*Friedhof*, literally peace-court) refer to the female genitalia as do the dense forest and the nymphs [nymphæ, a medical term]."

Truly, to quote Freud's own words,[3] a symbolic geography

[1] *Die Psychoanalyse*, p. 38.
[2] *Fragment of an Analysis of a Case of Hysteria*, p. 120.
[3] *Ibid.*, p. 120.

of sex! Here at least, Bumke comments, sexuality and genitality seem to be one and the same thing.

But there is another revelation. This same patient had had a hysterical limp, according to Freud because she wanted to make a "misstep." Moreover, she had feigned an appendicitis, which was the substitute for a confinement, the "appendicitis" occurring just nine months after she had warded off a sexual assault. According to Freud's interpretation, she really wished that she had not done this and might have become pregnant.

As Mrs. Ladd Franklin has very cleverly said, "Since the Freudian wish may reveal almost anything, there will plainly be no difficulty in proving anything under the sun."[1]

Bumke then devotes several pages to the detailed account of other dreams, to the wholly arbitrary interpretation of them, and to an enumeration of many symbols (seventy-five are recorded) that help to camouflage the real content of the dream. What is the proof of all this, asks Bumke. When everything that man thinks, sees, or writes is in reality a symbol for something entirely different, where can the mind take hold and how is scientific thought possible? Or, applying this thought to psychoanalysis, why are not Freud's convictions, his thought, his contentions, his doctrines, merely symbolic?

The entire series of Freud's conceptions—the ego, the id, the libido, the symbolism of dreams, infantile fixations, anal eroticism, the unconscious, the preconscious—are fully discussed, always with the same results.

Finally we come to the question of the Œdipus complex, dearer to the hearts of the Freudians than to Freud himself, who now concedes that that complex has very little relation to the normal individual. Enough has been said, I believe, to prove that Alexander is scarcely warranted in stating that the objection to psychoanalysis is due chiefly to *emotional* prejudices, although there is enough in many of these doctrines and assertions to arouse considerable indignation. Alexander[2] is so certain that the Œdipus complex has found acceptance in the two most conservative places—in the Ox-

[1] "Freudian Doctrines," by Christine Ladd Franklin. *The Nation*, Vol. 103, October 19, 1916. p. 373.

[2] *Loc. cit.*, p. 70.

ford Dictionary and in *Punch*—that psychoanalysts who still think that they have to awaken humanity from its indolent sleep are tilting against windmills.

Aside from the fact that many thoroughly sane psychiatrists have never been convinced of the existence of the Œdipus complex, in normal individuals at least, not a word is said to the effect that the fight has been against the illogical reasoning of the psychoanalysts; and if, as Alexander suggests, psychiatry here in America "has assimilated so much from psychoanalysis" that it "is losing the respect of the rest of the medical world," this is because there are still a considerable number of logical thinkers left among medical men in America.

With reference to the Œdipus complex, of which some recent writers (L. P. Clark, for instance) speak as if it were a universally accepted doctrine, Bumke[1] quotes Hoche, another able psychiatrist:

> "I have tried my best, these many long years, to find a son who exhibited incestuous love for his mother and wanted to kill his father. But I have not succeeded. Other experienced colleagues have also searched in vain. The Œdipus complex flits about in literature as the Flying Dutchman does on the high seas. Every one talks of him, some believe in him, but no one has seen him."

Bumke states[2] that he has found a single authoritative instance, reported long before Freud's time. The reference is to a case recorded by Stendhal of a boy, seven years of age, who was eager to kiss his mother and wished that there were no clothes. He wanted to kiss his mother's breasts. His mother loved him passionately and hugged him closely, returning his kisses so fervently that he felt he must run away from her. When his father arrived and interrupted their kisses, the boy hated him. Bumke adds:

> "Here, then, is one case of sensual love in a child for its mother. I deny that there are many such. . . . That, in general, daughters are more attached to their fathers than to their mothers, and boys just the reverse, is not to the point. Freud is not even content with the assertion that *all* boys have an incestuous love for the mother and detest the father as rival and trouble maker, but claims further that boys often fear the father on the ground that he will revenge himself by castrating them, a fear that in dreams is symbolized as fear of blindness. That is the Œdipus complex."

1 *Die Psychoanalyse*, p. 46.
2 *Ibid.*, pp. 46–47.

Just why blindness should represent castration is not clear, Bumke comments, but Freud asserts that it does as positively as a chemist would assert that water is composed of hydrogen and oxygen. Bumke continues:

> "I can understand that a man caught in the labyrinth of symbolism will naturally encounter certain symbols and their interpretation everywhere and always.[1] . . . The entire Œdipus complex is rank nonsense . . . even if Stendahl did kiss his mother as he describes. . . .
>
> "In this connection I want to defend myself against the charge that my opposition to psychoanalysis is based on the preponderant rôle that it assigns to sexuality. . . . Sexuality is by no means the worst of human qualities, and if the part it plays in our lives were far greater than it undoubtedly is . . . we could and would come to terms with it.
>
> "*What I oppose in psychoanalysis is its method* [Bumke's italics]; its practice of making assertions that no one can disprove, not because they are true, but because there has never been even an attempt to prove them; its habit of presenting far-fetched and improbable explanations as facts; its utter disregard of the simple rules of logic and of critical judgment."[2]

There is no doubt that in this last sentence the German author utters the chief condemnation of psychoanalytic theory.

The next few pages of the critique are devoted to a refutation of Schilder's claim that there are two kinds of logic—scholastic logic and a newer logic that has gone back to intuitive insight into reality—with the latter of which psychoanalysis is in accord.

This is followed by a very careful evaluation of Hans Kunz's paper on the factual significance of psychoanalysis, and a discussion as to whether or not psychoanalytic doctrines can be regarded as scientific truths, or whether there are several kinds of truth. As was intimated above, all save rabid psychoanalysts will ally themselves with Bumke in holding that logic and critical judgment must remain the foundation upon which all true scientific investigation is based. After a very prolonged reference to "primary anthropologic-

[1] Some one, better versed than I claim to be in either Greek or Norse mythology, would do well to name a complex that implies hatred toward the son on the part of the father. Any number of times I have seen instances, even among professional men, of a father's envying the son's success, either socially or professionally, to the point of hatred. That mothers are similarly deeply envious of their daughters has also been known to me.—Sachs.

[2] *Die Psychoanalyse*, p. 48.

psychological perception theory" and what not, Bumke is anxious to return to earth. What is the crux of the whole matter, he asks.

The chief question is, Can we rationalize the unconscious? Can we attribute to it the ability to think and understand? That one often does not know what one has previously thought is as true as that still more often one cannot explain why certain thoughts and not others emerge from the unconscious. But can one think without knowing it (while thinking)? Can one draw conclusions and reflections without being conscious of it? The question is simply whether in our consciousness and in our conduct we occasionally find content and effects that necessarily imply reflection and yet that did not result from conscious thought. Bumke continues:

> "Freud deserves great credit for having repeatedly called attention to the facts that would seem to justify such an assumption. Undoubtedly it very often *seems as if* a man had reflected upon a certain subject while he himself is firmly convinced that he has not thought of it or about it.
>
> "This premise I grant, but I dispute the conclusion that the individual (strictly speaking, his consciousness) actually did no thinking. We are apt to forget the majority of our experiences, and those that we do not think about with pleasure we forget sooner than others, but the emotions connected with them survive and affect our consciousness. Furthermore, from the mysterious depths of our bodies emanate instinctual excitations and desires which we cannot explain logically, and which come into more or less successful conflict with our ethical desires. All this takes place in consciousness, but is not often formulated in language, so that very few individuals can give any sort of account of this phase of their inner experiences. For that reason, Bleuler can claim that the layman knows the unconscious as well as many doctors do. The layman designates as unconscious whatever is not put into words in consciousness, and his subconscious is almost identical with what I designate as the psychology of the emotions."[1]

Even intellectual activities not infrequently enter into consciousness without being formulated in language. Bumke goes on: This imperfectly formulated thinking is utilized by many people to play hide-and-seek with themselves. It is easy to forget painful or unpleasant things, and if one cannot dispel them altogether, one can at least avoid the clarity that the word (even though unspoken) gives to thought. Then should the thought lead to action, one can persuade oneself that what was not formulated was not consciously experienced,

[1] *Die Psychoanalyse*, p. 65.

and from that it is an easy step to blame the unconscious for the emotion and action connected with the thought. Herbart says truly that the clarity of a thought may reach zero, but that ideas may persist below the zero point, that they may be elaborated *in the unconscious* is not true. At least, no one has proved it.[1]

The fantastic "subconscious" of Freud is not acceptable to Bumke; he examines it from every angle, tries even to recognize the preconscious (not exactly in the Freudian sense), but concludes:

> "A subconsciousness, an unconscious psychic activity, psychoanalysis has never and nowhere proven. The unconscious in the psychoanalytic sense is simply that which we would rather not know about ourselves, but unfortunately know only too well. . . . We men of science and physicians are accustomed to relate the unconscious—which is, after all, only the unknown and the unintelligible—to definite states of the brain. Even if we were to explain psychic processes as due to a psyche entirely independent of somatic processes, we cannot attribute to the unconscious qualities of the conscious psychic life unless we can demonstrate these qualities."[2]

To be sure, the psychoanalyst makes light of this:

> "Like a magician, Freud presents now the psyche and now the soma (*das Physiche*) until it looks as if he knew all there was to know about both. But one must not ask how it all happens, and above all one must not expect logical proof or evidence. When, for example, Freud asserts that his libido theory rests scarcely at all upon a psychological basis,[3] then I would like to know why he has written volumes trying to prove that it is purely psychological; and again, when he claims that the foundations of the libido theory are essentially biological, I inquire: If so, what do these physiological foundations look like?"[4]

Always the same objections—want of logic, very little in the way of reliable facts, and much pure assumption. And yet Bumke finishes his critique in a perfectly fair spirit, which Freud's followers and opponents may well take to heart. The German psychiatrist says:

> "Now let me attempt to forecast the future of the psychoanalytic movement. Freud himself stated in 1925,[5] 'At the present time German

[1] *Die Psychoanalyse*, pp. 66–67.
[2] *Ibid.*, pp. 70–71.
[3] *Collected Papers*, Vol. 4, p. 36.
[4] *Die Psychoanalyse*, p. 72.
[5] *An Autobiographical Study*, p. 298.

psychiatry is undergoing a kind of "peaceful penetration" by psychoanalytic views. While they continually declare that they will never be psychoanalysts, that they do not belong to the "orthodox" school or agree with its exaggerations, and in particular that they do not believe in the predominance of the sexual factor, nevertheless the majority of the younger workers take over one piece or another of analytic theory and apply it in their own fashion to the material.' That is true enough and I am perfectly satisfied that it should be so. Psychoanalysis will follow the same path that many intellectual movements, both good and bad, have taken. At first a few secede, as Jung, Adler, and Stekel have broken away from Freud; then the doctrines are popularized and in the process are diluted and emasculated; and finally nothing is left of the kernel of the theory. Even to-day in the daily press and in novels, and indeed in many medical publications, one finds fragments of the original analytic dogma which Freud himself could scarcely approve. Among physicians—to say nothing of the laity—for every one who is orthodox and a recognized follower, there are at least a dozen who have adopted only parts of the whole doctrine. One, for example, will reject practically all the conclusions and yet profess belief in the method; and many others—without using the method—predicate the sexual origin of nervous diseases and 'help' their patients by saying it."[1]

Is it a mere accident, Bumke asks, that Adler and Jung, thorough students of psychoanalysis, have renounced the doctrine as a whole? Bleuler has become lukewarm. Is there no reason for this?

"Still, the truth remains that psychoanalysis has left its imprint upon the thoughts of many psychiatrists and other physicians. Freud himself has stated that the theory of the advantage to be gained by illness and of flight into illness quickly became popular.[2] We are indebted to his teachings in many other ways, too. Our present-day conception of the influence of early childhood experience, our ideas of war neuroses and of traumatic neuroses, indeed of pathological developments in general, would not have been possible without Freud, even though they may be at variance with Freud's theories. A later generation will probably realize that psychoanalysis was a necessary stage of psychological evolution, and gave us many points of view that could have been smuggled in only under the flag of the unconscious."[3]

"What will be the future course of this evolution?" Bumke concludes.

"Although Freud claims the term psychoanalysis exclusively for his doctrine and his school, not merely Bleuler and Jung, but Kronfeld and

[1] *Die Psychoanalyse*, pp. 72–73. Bumke has not visited these United States so far as I know. His statement is applicable to American conditions just the same.—Sachs.

[2] *An Autobiographical Study*, p. 284.

[3] *Die Psychoanalyse*, p. 74.

Allers are to-day cited as star witnesses for psychoanalysis—an example of the same carelessness that leads many medical writers to attribute to psychoanalysis the discovery that the unconscious is the unknown X whose activity is in evidence everywhere. As a matter of fact, we have always been cognizant of the unconscious. As for Kronfeld and Allers, they have expressed themselves strongly against the method of psychoanalysis; Jung has turned against 'its ridiculous and almost morbid emphasis upon the sexual point of view'; and Bleuler among other things rejects 'an absolute unconscious of psychic events.' Taking them all together, actually nothing is left of Freud's doctrine; and what is more, the line between adherents and opponents disappears. Finally the terms 'unconscious,' 'psychoanalysis,' and 'individual psychology' will regain their original meanings—we all believe in the unconscious, we all analyze the psyche of our patients, and we all try to take into account their individualities, the psychic characteristics peculiar to them.[1] So far, so good. Freud's method will disappear, since it would mean the downfall of all science and the end of all research. But certain revelations which we owe not to any particular method, but to the psychological insight and understanding of Freud, of Janet, and of many others—above all of Friedrich Nietzsche—these will be left, as the overflow of the Nile leaves behind it in the end not water, but fertility."

We may not appreciate this last effusion of Bumke, but we will all surely endorse his closing sentiment: "There can be no psychology that does not attempt to understand the whole man, and this cannot be achieved with any certainty except through study of the individual."

[1] "It is well to remember that the alienist of former days was in the habit of analyzing mental processes by determining the original and fundamental psychic symptoms and by endeavoring to ascertain the causes that led to the development of nervous or mental phenomena. There is one great difference, however: we did not insist that some sexual irregularity must be the cause."—Sachs, *loc. cit.*, p. 78.

A PSYCHOLOGIST LOOKS AT MENTAL HYGIENE *

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THE particular bias that keeps a scientist sawing wood in his own back yard has advantages as well as limitations. It circumscribes his task and permits him to sharpen tools for his particular purpose, but it may prevent his seeing relationships to other woodpiles, which are both interesting and important. A scientist's first impression about mental hygiene is more than likely to be that, whatever mental hygiene is, it doesn't quite belong in anybody's yard; it is not a recognized specialty. And next he notices that neither is it one of the organized services regularly maintained by society, like education, law, public health, or national defense. He is told on the positive side that, for one thing, mental hygiene is an idea, a movement, a point of view.

Now a scientist very well knows that an idea may become an extremely powerful force if it takes hold of men's thinking. The idea of natural selection, for example, changed our outlook in many directions within a few decades. Moreover, the central thought in a new outlook does not require at the outset to be scientifically a completed product, rather the contrary; indeed, its early formulation may even prove in some respects to have been scientifically ill-founded. It must, on the other hand, present challenging problems that command scientific as well as popular interest because they involve new values and new relationships. It is incumbent upon a genuine scientist, therefore, to exercise his natural curiosity for truth by being willing to explore any promising new idea that even remotely touches his field. His judgment about it will be subsequent to this exploration, his training having schooled him against the hazards of prejudgment.

Has mental hygiene anything to suggest to modern psy-

* The third of a series of articles begun in the January issue of MENTAL HYGIENE.

chology, or *vice versa?* In order to answer, we may briefly look at each of these interests from the standpoint of the changes in meaning and emphasis that they have respectively undergone during recent years, because every living subject has some of the characteristics of a movement. Moreover, North America has been the locus of rapid development in both of these subjects.

The term mental hygiene is a product of the twentieth century, but a part of its modern connotation is as old as the history of medicine. It is because the conception has altered its main point of emphasis and is still in a formative state that any attempt at precise definition would necessitate selection of content and perhaps be a source of confusion through being somewhat out of date or limited in perspective. For our present purpose, three main aspects of mental hygiene may be distinguished which have been featured as central in succession, although all have remained pertinent to the movement. In its early use, the term mental hygiene, technically as well as popularly, referred to advanced forms of mental disease or of gross mental defect, with emphasis upon the need of more intelligent and humane care—of asylums rather than mad houses. Later the term came to include a more rational outlook, with scientific curiosity as to the causes of mental illness and attempts to treat such conditions in their incipient stages with a remedial end in view. Mental hospitals with measures for active treatment, physical and mental, were now to supplement if not take the place of asylums. And contemporary with this advance, a need was now felt and a hope aroused, so that in due course a crop of mental clinics sprang up over the land in association with organizations and institutions that have to do with cases of grave deviation in human behavior. Great as this advance was over the earlier non-rational view and *laissez-faire* policy, it proved to be only a stage in a growing movement. More recently mental hygiene has come to mean the discovery and application of principles that will help to preserve rather than simply to restore mental health for people through every period of life. The objective is to enable the individual so to understand himself and control his adjustment in accord with principles conducive to health of mind as well as of body that

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* The third of a series of articles begun in the January issue of MENTAL HYGIENE.

chology, or *vice versa?* In order to answer, we may briefly look at each of these interests from the standpoint of the changes in meaning and emphasis that they have respectively undergone during recent years, because every living subject has some of the characteristics of a movement. Moreover, North America has been the locus of rapid development in both of these subjects.

The term mental hygiene is a product of the twentieth century, but a part of its modern connotation is as old as the history of medicine. It is because the conception has altered its main point of emphasis and is still in a formative state that any attempt at precise definition would necessitate selection of content and perhaps be a source of confusion through being somewhat out of date or limited in perspective. For our present purpose, three main aspects of mental hygiene may be distinguished which have been featured as central in succession, although all have remained pertinent to the movement. In its early use, the term mental hygiene, technically as well as popularly, referred to advanced forms of mental disease or of gross mental defect, with emphasis upon the need of more intelligent and humane care—of asylums rather than mad houses. Later the term came to include a more rational outlook, with scientific curiosity as to the causes of mental illness and attempts to treat such conditions in their incipient stages with a remedial end in view. Mental hospitals with measures for active treatment, physical and mental, were now to supplement if not take the place of asylums. And contemporary with this advance, a need was now felt and a hope aroused, so that in due course a crop of mental clinics sprang up over the land in association with organizations and institutions that have to do with cases of grave deviation in human behavior. Great as this advance was over the earlier non-rational view and *laissez-faire* policy, it proved to be only a stage in a growing movement. More recently mental hygiene has come to mean the discovery and application of principles that will help to preserve rather than simply to restore mental health for people through every period of life. The objective is to enable the individual so to understand himself and control his adjustment in accord with principles conducive to health of mind as well as of body that

he may successfully anticipate and avoid the ill effects of their breach.

This third and newest aspect—namely, the effort to understand the mental pitfalls of ordinary people, whatever their stage or station in life, and to assist them to recognize safeguards that will promote the best mental health and adjustment of which they are capable—is slowly, but surely coming to the fore as perhaps the outstanding interest in mental hygiene. Of course, the earlier interests of proper custodial care and of active treatment for those already ill still persist and must persist along with this new interest looking toward prevention, but the former are no longer the only aims or necessarily the most important in the movement. The custodial and treatment aspects are still, it must be admitted, the most prominent issues to-day as judged by actual public policy and expenditure, but what society will accept in future as the proper emphasis in social values only the movement itself can reveal. Foresight with a view to preserving mental health for the present generation in a changing world is manifestly a more challenging and perhaps more difficult and important problem than hindsight with attempts to restore impaired health. The mental-hygiene movement embraces both of these outlooks, with growing emphasis upon prevention; and it asks of the various sciences that have to do with man what light they can cast upon these problems.

A central idea in present-day mental hygiene, then, is a positive view of normal mental health for the developing individual, rather than a negative view of loss of health, necessitating measures for its restoration. To discover general principles relevant to this outlook is a scientific task, not easy, yet not nonsensical or necessarily impossible. It will require new angles in research and careful testing of all conclusions by concrete application. The task is comparable in some ways to that of preventive medicine, but with wider implications and somewhat different methods.

Broadly speaking, two approaches to the goal of health are conceivable—namely, from the pathological or from the normal. The former starts with gross disorders recognizable as diseases, and reasons that if a definite cause can be found, then a specific with resultant cure may be looked for,

and eventually, through prevention of its cause, the disorder may be eradicated, as the bacteriologists have so conclusively shown in their province. Hence to find and control the cause of each mental disease would be the right road toward mental health. The catch in this is the slowness with which mental diseases have yielded to the doctrine of specific causes as compared with physical diseases, and the many forms and degrees of mental ill health for which multiple causes of devious kinds, perhaps environmental rather than somatic, seem to be indicated.

Approach through the normal, on the other hand, presumes multiple causation. It endeavors to analyze the main factors in a situation that involves human relationships and to define the functional variation that can be tolerated in these without resulting in significant dysfunction in conduct or consciousness. If the variables in the situation can be socially controlled within these limits, dysfunction will be prevented or relieved, even though there is no definable "cause." This is a doctrine of "adequate equilibrium" as contrasted with the doctrine of "cause and cure." These approaches are in no sense antithetical, but complementary. Mental hygiene recognizes the place of both, but has been constrained by experience to look more and more toward positive principles in terms of normal functioning—*i.e.*, the conditions of equilibrium between given persons and their problem situations.

From a scientific standpoint, this necessitates certain departures in method from the view that we have characterized as "cause and cure." In the first place, the quest for principles of positive health cannot be reduced to the level of a purely "objective" science because the subject matter is, perforce, ordinary people actively participating in daily situations, with all the wealth of attitudes and meanings, successes and failures, which that entails. In the last analysis, the test of healthy mental functioning must be found not in a test tube, but in the way a person actually thinks, feels, and acts—*i.e.*, lives.

In the second place, the scientific principles underlying the functioning of individuals cannot be wholly revealed in situations such as are afforded by a laboratory, a clinic, or a hospital, important as these are. In addition, inductive study

must be made into those so-called practical theaters of action where the full complexity of real life obtains, as in the home, the school, the factory, the leisure hour; and sample observations must be continued there over sufficient periods of time to reveal the trends and variations in adjustment of the persons concerned. Here the conventional distinction between the narrowly controlled laboratory situation and the socially controlled practical situation disappears for the inquiring scientist. After all, it is not the type of situation that makes a study scientific, but a systematic plan and method of analyzing the relationships involved and of reducing them to general terms. Method is always a tool and must be adapted to the setting of the problem.

Thirdly, because persons must be participators and situations real, the types of experimentation that can be used in studying the adjustment process must be those most appropriate for human situations—that is, control of motivation with observation of the learning that results. In short, the procedures of investigation that will offer principles of normal adjustment will be primarily educational in character, and hence will involve the application as well as the investigation of these principles. In other words, when one deals first-hand with problems of human nature, the conventional distinction between pure and applied science becomes pointless. In fact, this distinction assumes meaning only when a scientific problem is abstracted so far from real life that it becomes another problem to relate it again to human affairs. Mental hygiene holds that its basic problems lie first and last within practical situations. In the face of this, it is always interesting to note which of the sciences have no reply, except to reject such problems as "unscientific," instead of seeking methods adequate to the task of their solution.

Finally, the search for the principles governing mental health frankly applies a conception of value in recognizing that healthy functions can be differentiated from those that are unhealthy or pathological and that the former may be regarded as an end, the conditions for which are to be ascertained. This point of view is never a stumblingblock to scientists with medical training, but others whose work is less

close to human material sometimes take exception to it. The stock objection one hears is that values should never be countenanced in scientific work—that science *per se* knows no values or, if one will, that every scientific fact has its own inherent value. Strictly, I do not believe that any such position can be defended either on logical or on philosophical grounds, in as much as every so-called "fact" involves an act of selection in the picking of it out from some greater whole, and this step of abstraction already postulates an evaluation which the scientist, perhaps unwittingly, utilizes in selecting his fact. To this extent at least we cannot avoid values if we deal in facts. But apart from this apology on behalf of values in all scientific work, it must be said, in fairness to the mental-hygiene conception of normal health and its preservation, that there is no thought of a normative pattern of adjustment to which individuals should properly conform. The lessons of biological science, of individual differences, of developmental trends, of adaptability through learning, have been too well mastered for the concept of normal health ever naïvely to be given any such rigid meaning. Not a universal norm, but the well-being of the individual is the objective. The test of normality in adjustment can never be in terms of a defined standard with supposed intrinsic value, but rather depends upon whether the degree of learning at a given stage is an adequate preparation for progress into the next stage of adjustment. In a genetic process values must be interpreted as developmental and be expressed in terms of *learning* to adjust.

The above points of method, of course, are not peculiar to mental hygiene; for the most part, they are the stock in trade of our modern scientific outlook, especially of those disciplines that relate to man in action. The difference lies mainly in the value that mental hygiene attaches to the healthful adjustment of the person as such. Mental hygiene, though not a science, looks to a wide array of sciences for its constructive principles. In what has been accomplished in its field to date, the chief debt is clearly to the psychiatrist. With inadequate facilities, psychiatrists have had to carry the heavy responsibility of caring for the mentally ill and of trying at the same time to advance the sum of knowledge concerning these con-

ditions. On the somatic side, they have canvassed such leads as the medical sciences have offered for their problems; on the analytic side, they have thrown a flood of light on the dynamics of mental processes; whilst on the side of aberrant behavior, their guidance and counsel have won them a permanent position of prestige. Scientific and professional leadership in mental hygiene thus properly rests with the psychiatrist. But the contribution by psychiatry is characteristically from the side of the non-normal, and the interest of mental hygiene is, as we have seen, no longer wholly confined to the relatively small proportion of our people who have already fallen by the way. Whence, then, will come the scientific knowledge and research required for a constructive program of mental health for the majority in the community?

Obviously, the answer would seem to be through adequate teamwork among workers of many types who have an interest in and something to contribute to the question of how individuals adjust. The psychiatrist would be the first to acknowledge that in point of numbers, as well as of training, he cannot cover the whole ground. He is probably not in as good a position to advise, say, on the proper management and training of infants as is the pediatrician, nor has he the acquaintance with the normal pre-school child and his parents that would be expected of the child psychologist. And as we contemplate the spread of years in life, the web of relationships affecting the individual becomes rapidly larger and more intricate. Thus in their respective spheres of practice, the nurse, the social worker, the teacher, the parent, the personnel officer, and so forth, find in the responsibilities of the day-to-day job questions concerning the adequate adjustment of themselves or others that give point and meaning to the principles that mental hygiene holds to be important. This represents the side of public demand and in it lurks the immanent danger that mental hygiene is not yet scientifically equipped to meet this growing demand. But more important still is clear recognition of what is required in order to meet these questions that people bring. Mere abstract knowledge, prescriptions for this or that difficulty, are by themselves of little use. What is required is an educational procedure based upon sound principles and so conducted that persons can see

and master for themselves those insights and habits that make for normal adjustment. To ascertain how best this educative process can be achieved for the many who are seeking it is a major task of research and experiment. And it is a laboratory problem, not in the conventional sense, but in the larger social sense of the community with its human relationships.

Thus the practical demands upon mental hygiene, instead of being a menace that science can meet by *laissez faire,* open a wider avenue of scientific effort. Psychiatry, pediatrics, and other medical branches are playing an important part, but the problems here are such that teamwork requires also the contributions that education and the social sciences have to offer. Consider sociology. When one begins to study closely just how one individual adjusts to others, it will be obvious, for one thing, that every individual is confronted with the task of learning to adjust at each stage in life to other persons who have equal, greater, or less maturity than himself. But he does not adjust to these merely as so many individuals, rather they are individuals of his family or some other; one is a schoolmate, another belongs to a rival gang, a third to a different racial group or a different economic class, and so forth. The facts of adjustment, therefore, cannot be understood as simply between persons, but between persons tied into the structure and function of an organized society which is itself fashioned according to the patterns of our particular culture or mixture of cultures. The individual's behavior is an outcome in part of the meanings he comes to attach to these social institutions of which he is a part. Now it is the business of the sociologist, the anthropologist, the economist, the political scientist, and so forth, to furnish suitable conceptual plans for understanding the complexities and forces in the social structure, what they mean to the person who shares in them, and how they mold his attitudes and conduct. It is idle, then, to suppose that the social factors that make for equilibrium in adjustment by the individual can be really understood, let alone managed, without the assistance and coöperation of these sciences and without an attempt on their part to interpret their findings in terms of human behavior. Mental hygiene does not show

how this is to be done; it issues a challenge that it be done, and it suggests that the well-being of the individual is a reasonable point of orientation for the undertaking. The preventive interest of mental hygiene thus offers a common meeting ground.

Where does psychology stand to-day on these questions? Has it won a place on this scientific team? Psychology, like mental hygiene, has a past. It is a developing science and hence is notoriously hard to define without running into controversy or misunderstanding as to its central point of emphasis or its main objectives. Roughly speaking, the movement in psychology during recent decades has certain resemblances to that in mental hygiene, but has proceeded from other directions. Separating slowly from philosophy in the past century, scientific psychology first took the form of detailed laboratory studies of particular conscious processes and their determining physical and physiological conditions. This "psychophysical" approach stressed the content or structure of the mind, with a bias for explanatory purposes toward a rather meager knowledge of neural structure and function. From another direction, the introspective point of view, with a doctrine of the "association" of conscious states, was felt to be a main objective for psychology. Later a biological interest entered, emphasizing in addition the objective behavior of the organism to its immediate environment. And this broadening of the horizon was paralleled by an interest in more complex mental processes, such as those of perception and learning. In time also statistical techniques were added to other quantitative procedures as a useful aid in generalization.

In this youthful period of the science, many aspects of man were thus explored, but it can scarcely be said that the entire man as an integrated personality had yet been discovered by psychology. An enthusiasm for isolated functions, oversimplification, and quantitative precision, coupled with a certain nervousness as to whether or not these inquiries were strictly "scientific" in a particular quantitative sense, combined to divert the aim of psychologists from man as a person, so that they missed that mark perhaps even more completely

than philosophy ever had. Nor could they see any helpful middle position between the extremes of experimental abstraction in the laboratory and speculative abstraction in philosophy. Thus formal psychology has not been particularly receptive, for example, to any of the psychoanalytic theories of the ego, but at the same time it has remained singularly backward in offering any constructive views as to how a personality is constituted and actually maintains its integration. Biological problems have obscured the vision of social problems. A theory of social psychology, for instance, that would stimulate research and help tie together the many approaches to the study of man has been extraordinarily slow in developing and perhaps can fairly be said to be still wanting.

After the turn of the century, an interesting correction of the piecemeal study of man was attempted in America in terms of a "functional" point of view. As has been characteristic of psychology in the New World, this program was more eclectic than reconstructive; it hoped to bring into an harmonious whole both experiential facts and objective facts of behavior and to state the functional dependencies obtaining throughout these as an inclusive view of human nature. The aim of synthesis was commendable, but unfortunately nothing new had been added to avert the philosophical difficulties of relating mind and body, and the social determinants of individual behavior were not yet clearly realized nor their study frankly envisaged. Consequently, Behaviorism promptly appeared, with its simple solution of throwing consciousness overboard and dealing scientifically with man solely as a physical organism reacting in a biological environment.

The World War brought significant changes in thinking and outlook that left few if any branches of knowledge unaffected. It brushed aside subtleties of academic debate and compelled a franker facing up to the realities in human affairs. Psychology is reflecting this influence in many directions. It has migrated beyond the laboratory and classroom into applied fields, clinical, industrial, educational, and so forth. It has likewise extended its horizon throughout the scale of life,

from the infant to the adult as well as into the infra-human. What the real values are in this movement in the science remains to be seen; opinion is divided within the ranks of psychologists and probably more so outside their ranks. But this is always the case where a new outlook is seeking place among older approaches. In any event, new energy and new techniques are evident, though their coördination as representing a unified interest with an adequate theoretical as well as practical foundation is not yet evident.

If one were to venture an attempt to generalize this emerging aim within present-day psychology, I would say that it is to begin with man as an integrated personality and to study how he learns to adjust to the particular life situations in which he finds himself. The living individual in all his ordinary settings is thus the central idea from which we start and to which we return, however far our more detailed analyses may have led us. From this standpoint, psychological study is necessarily genetic in outlook; it is interested in the whole constitutional make-up and development of the individual from stage to stage through life and in how the growing personality is affected by the complex physical and social environment.

It will thus be seen that these more recent trends of psychology and those of mental hygiene, particularly on its preventive side, have much in common. Both aim to deal with people as one finds them, psychology with the noncommittal aim of finding principles that underlie human action, mental hygiene with the commitments, characteristic of the teacher and physician, of evaluating conditions that contribute to a desired end, good adjustment, and of trying to help the individual master these. Psychology, therefore, makes no apology for being interested in mental hygiene and *vice versa;* they are by no means identical, but they are significantly complementary.

But it is one thing to have a point of view and quite another to carry it into effect in terms of well-planned investigations and of useful instruction. One has only to glance through the pages of the introductory textbooks in general psychology for the past decade to realize the transitional and unsettled

state of the subject. Nevertheless, in so far as we are now learning where to start—namely, with the integrated individual in his social setting—there is promise that a psychological point of view can be developed with a program that will help unite the biological with the social sciences in an endeavor better to understand man. Toward this goal for science, mental hygiene offers a strong incentive in its quest for principles of positive health.

TRAINING THE HIGH-GRADE MENTAL DEFECTIVE FOR COMMUNITY LIFE*

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THE present article deals with recommendations for the training of high-grade mental defectives in institutions for future life in the community. By high-grade defectives we mean morons and border-line cases with intelligence quotients of the higher range, let us say roughly from 65 to 80. The remarks apply to favorable types that, from the standpoint of intelligence, should do fairly well outside of an institution if properly trained.

High-grade mental defectives are the most hopeful, but at the same time often the most discouraging cases in institutions. Hopes are entertained while the child is young, but these hopes are too often dashed when he arrives at the time when he should be able to leave the institution and go to work. He may be given a trial in the community at the insistence of friends, or because a trial seems advisable, or perhaps because he runs away and makes a trial for himself.

The results in these cases are by no means always favorable. Of 1,164 cases reported by Storrs[1] discharged from Letchworth Village, 412 could not be located and 122 had been transferred elsewhere, leaving 630 cases whose adjustment could be investigated. Of this group 72.75 per cent of the males and 74.86 per cent of the females had been successful. Probably, however, a considerable number of the 412 who could not be traced were not successful. Hence, the total successes could not be expected to reach the above percentages.

* Presented at the Fifty-fifth Annual Meeting of the American Association for the Study of the Feebleminded, New York City, May 25, 1931.

[1] See "A Report on an Investigation Made of Cases Discharged from Letchworth Village," by Harry C. Storrs, M.D., *Proceedings of the Fifty-third Annual Meeting of the American Association for the Study of the Feebleminded*, 1929.

Fernald's report[1] on 470 male patients discharged from Waverley states that 250 of this group were getting along in the community, either earning wages or living at home, 54 had died, and the remainder had either been readmitted to Waverley, arrested, or sentenced or committed to penal or other institutions. It is undeniable, therefore, that there are many unfavorable results.

The placing of girls in the community after they reach the period when they should go to work seems surrounded with hazards. Success is uncertain despite careful investigation and trials. This is true to a less extent with boys, but delinquent conduct of varying degrees is not infrequently encountered with them also. Why do some children with excellent institutional training do less well in the community than others who have never been in institutions? In all likelihood it is not solely the inherent personality or faulty inheritance of the institutional child that makes him less successful than one with similar mental handicaps who has been reared in the community.

Not infrequently a situation like the following is met. A child with an intelligence quotient of, let us say, around 65, at the age of seven or eight years, on account of bad home surroundings, death of parents, or for other reasons, is committed to a school for mental defectives. If a girl, she may remain in the institution until she is eighteen or over. Then she may be tried on parole. Very often indeed she does not do very well. She proves to be unstable, sulky, handicapped, or there may be sex irregularity, either threatened or actual. The result is that she is returned to the institution as a failure. I do not refer to those who come to the institution at the age of twelve or fourteen already delinquent. I refer to the younger group admitted around the age of eight years or before, where suitable training and environment should bring about good results.

The causes of the difficulty with this type of child are not far to seek. No child, whether defective or otherwise, who is brought up in an institution with large groups of children,

[1] See "After-Care Study of the Patients Discharged from Waverley for a Period of Twenty-five Years," by Walter E. Fernald, M.D. *Ungraded*, Vol. 5, pp. 25–31, November, 1919.

many of whom are low grade mentally and have unfavorable character traits, has fair opportunities, in spite of good training in many ways.

In the training of normal children, the importance of favorable home influences, good environment, and proper surroundings are stressed. The same influences are even more necessary for children who are mentally handicapped. When these handicapped children turn out badly, one is apt to blame the parentage, or the inherent nature of the child, or his dull or impaired intelligence, whereas the surroundings often have supplied the unfavorable influences. With mentally handicapped children, therefore, advantages offered by institutions may lead to disappointment unless certain other favorable influences exist.

In the education of any child, *social training*—that is, a training by which he learns to live in a proper way with others and to respond favorably in social relationships with others—is an absolute essential. In most institutions teachers are with the child less than half of the time. After classes, the child returns to the ward and comes in contact with large groups of children, some at least of whom are markedly defective, delinquent, uncontrolled, abusive, and profane. These influences and the lack of individual guidance from some one who is an adviser, counselor, and friend—and hence furnishes the inspiration generally given by a wise parent—goes far toward explaining untoward results.

Of the many unfavorable influences that are brought to bear on young children in large institutions, one is the management of sex problems. If a group of adolescent girls are segregated in an institution for women only, and never allowed to see boys or men, sex interests become unduly stimulated, so that sex becomes the chief topic of their lives. The broad interests of the developing young girl are extremely limited in such surroundings. When such girls have an opportunity to see the opposite sex later, they do not conduct themselves normally and are apt to behave in a childish way and be easily taken advantage of, or to go to great extremes on their own initiative. If, on the other hand, they see something of boys when they are young, and if other interests are allowed to develop, as in normal community life, sex problems are less

in evidence. This problem of sex is cited as one of many examples of the artificial influences unavoidably encountered in large institutions.

Recently, on a visit to one of the state schools that houses nearly two thousand patients, two wards were seen which contained a large group of young boys of relatively high mentality and of trainable type. The superintendent stated frankly that he did not consider the institution a proper environment for these young children. He pointed out that the large institution has a definite function to perform—namely, segregation and training, under supervision, of a large percentage of the patients. This régime cannot be modified sufficiently to meet the needs of a small group of children. Still, for this small group proper training for life in the outside world is vital. The fundamental need of these young children is a type of rearing and social training that is practically impossible in a large institution, regardless of how well the institution may be administered.

In view of the above considerations, we venture to make the following recommendations:

It is suggested that a separate department be established in institutions for mental defectives for the care, training, and preparation for life of high-grade defectives. These children should be kept apart from the rest of the institution. They should be managed as if they were normal children, as indeed they are in most respects, but they should be given special advantages in view of their mental handicaps.

The separate division should consist of the following facilities:

A nursery department should be established for the infants and little children of this group. This department should be in charge of a well-qualified nurse who would supervise diets and all of the health régime. Many state schools that care for little children already have this feature, although possibly not very fully equipped. As a part of this nursery department, there should be a nursery school in charge of a director. These nursery schools have already been established in a number of larger cities. This so-called school provides habit training, supervised play, and a number of other activities that stimulate mental and physical development.

Separate play-room space is necessary for the nursery school, with some adjoining ground.

After the nursery school, the child should attend kindergarten. Children in kindergarten are old enough to require surroundings away from the institution, so while the infants might be in a separate ward of the institution, kindergarten children should be in cottages quite apart from the main building. These cottages should not be in charge of attendants, but of trained nurses with attendants or orderlies to help with the work. Kindergarten groups should, of course, be small.

Methods of conducting kindergartens are already well known in the state schools. In fact, many of these methods originated in state institutions years ago and have been put into practice in kindergartens in public schools in the form of sense training and other methods. An important point here, however, is that this kindergarten should be separate and distinct from the rest of the institution.

We now approach the parting of the ways from the state school proper. The children, having arrived at school age, should go to regular schools in the community, if possible to attend special classes or to have the benefits of a modified curriculum. The child at this time should be separated from formal institutional life.

We would suggest that plans be worked out whereby the institution would establish boarding homes for some of these children. Methods of conducting these have been well organized in many communities. The home should be selected and supervised by the institution. Arrangements would be made for paying for the child's care, whether by the state or otherwise. The child would thus have family influences; be sent to school, church, and entertainments; and take part in the regular life of the community.

This plan would overcome a most serious objection to institutional life—*i.e.*, the limited associations, the lack of training in social responsibilities, and other limitations.

An arrangement suitable for some of these children is the so-called junior colony as developed at the Rome State School. This colony provides for a small group of young children living in a house rented by the institution in a town or village,

the house being run by a matron or married couple employed by the institution. These children attend the local school and take part in the local community life.

These children, either in boarding homes or small colonies, should remain under the above régime until they are old enough to leave school. In the course of time, they should be taught various trades—farm work, domestic work, and so on, in accordance with their capacities—so that they may be placed out to work, but still under the general supervision of social workers from the institution. Whether they were eventually discharged, continued on parole indefinitely, or returned to the parent institution, would depend upon circumstances.

Of course one should be under no illusions about the future of some of these children. Some of them are constitutionally handicapped, not only by inferior intelligence, but by an unstable personality and limited emotional control. However, many have potentialities that fail to develop in the ordinary régime of the institution.

It is believed that the above recommendations apply not only to state schools, but to all institutions in which children are cared for—viz, orphanages, institutions for dependent children, and other similar institutions. If this plan can be put into practice, the early hopes that are entertained for these children may be realized. State schools, the leaders in the early introduction of certain kindergarten methods and manual-training methods, have contributed far more to the education of normal children than many persons appreciate. If they can now make further contribution toward the social training of children, it will be a worthy object of their endeavors.

AN APPROACH TO A DIFFICULT CHILD CARE PROBLEM *

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IT is generally recognized that the personality of the problem child cannot be reduced to strictly definite categories. Nevertheless, we have found a number of cases in which individuals have presented certain similar personality traits that may be included under the general term of narcism.

The child at birth is a born narcist and continues so during his early development. His discovery of others within the environment, as well as the realization that he must share his beloved objects with others, causes him to give up part of his narcistic love. Normally this has taken place before the sixth year, for at that time his entrance into group life necessitates a still further sacrifice, a part of this narcistic love, to the development of a group sense. Persistence of this excessive narcism in children ranging in age from twelve to sixteen always denotes a fixation at or a regression to the earlier level.

Children of this type are readily recognized by those who are professionally responsible for their care as particularly difficult problems. Their presence is quickly known by the disturbance and uneasiness that they cause. Complaints from the supervisors, assistants, and teachers who come in contact with these children are more numerous and frequent than complaints about other children. The problem children

* The data on which this study is based were compiled in the Child Guidance Department of the Hebrew Sheltering Guardian Society during the years 1925–1930. Mr. Blanchard was a member of the department while the study was being made.

themselves, however, do not realize that they are the active elements in such disturbances. Objectively, as a group, they present more or less definite reactions to the general body of children who, in turn, respond to them in a fairly definite manner. The subjective lives of these children likewise present a rather consistently uniform picture.

In outlining the personality traits of the children under discussion and the technique employed in treating them, the use of psychoanalytic nomenclature and interpretations will be avoided. We feel that the hypothesis developed by Freud and his followers concerning this group offers the clearest understanding of them; but in order to make the material here presented more readily assimilable by those unacquainted with Freudian literature, we will avoid developing this hypothesis and concern ourselves solely with the exposition of the technique employed in treating these children. Since the scope of this paper makes brevity imperative, we will not attempt a detailed and complete picture of their component personality traits, but will confine ourselves rather to a brief statement of the obvious characteristics observed in them. At this juncture we must not fail to point out that not all of these children have every one of the traits described below nor do they manifest these traits at all times. The degree and frequency of the manifestations, as well as the degree and character of the resistance against therapy, vary considerable among the members of the group.

The most outstanding trait is a constant and persistent desire to be the center of attention. In order to attain this end, these children use a variety of means which in many cases reach a high degree of systematization. Most commonly employed is a marked aggressiveness, which usually takes the form of boisterousness, clowning, bragging, volubility, verbosity, and, in those physically capable, bullying and actually striking others. They endeavor to be different and so set themselves off from the rest of the group by indulging and trying to excel in those activities in which the group in general is inferior—*i.e.*, writing poetry, playing chess, drawing, telling jokes, indulging in witticisms at the expense of others, giving ordinary speech and movements an histrionic coloring, and so forth. There have been in-

stances of these children's manifesting hypochondriacal tendencies to gain attention. We have even had a case where the child has resorted to a display of his eating powers in order to impress the group.

On the other hand, children of this type generally remain indifferent to those activities over which the children of the group are enthusiastic, and try in many ways to disparage the value of such activities. When other children are performing, they become excessively noisy, indulge in many antics, and do not stop until they have succeeded in diverting the attention of those present to themselves. Should their tactics fail, they react either by leaving the room or becoming thoroughly indifferent and paying no attention to what is going on. Another way of showing their resentment, when they are unsuccessful in their continual efforts to be in the limelight, is to resort to defiance of all authority and to become unmanageable. They then refuse to coöperate, are obdurately or sullenly disobedient, and seem to find keen pleasure in tantalizing those in charge. At such times disciplining the child or calling him to task for his behavior only brings about an indefinite continuation of the antisocial conduct.

These children succeed in creating a feeling of dissatisfaction among their cottage mates. They find fault with everybody and everything and yet do not seem to realize—and certainly never admit—that they are the cause of most of these difficulties. Direct attempts at analysis of the situation with them are unsuccessful. When spoken to, they appear preoccupied, apparently not following the trend of thought and usually trying to divert the conversation into other channels.

As a group, they stand out among their fellows as being less refined than the others. They are loud and boisterous, undoubtedly desiring to attract attention to themselves in this way. Their personal appearance, however, does not differ from that of most children. The ostentatiousness in dress that they occasionally show is not uncommon among children of their age. The contacts that they form with the group at large are of a superficial nature and in the majority of cases are made solely for the purpose of self-assertion

and of impressing those about them. The group soon senses the ulterior motive underlying their behavior and resents it strongly. The result is that these children become quite unpopular and are constantly "picked on" and ridiculed to a marked degree. In time, the group refuses to have anything to do with them, accuses them of being shirkers who use talkativeness in order to avoid their duties, and finally may go to the extent of making them the butt of its corporate irritability.

The children we are discussing have a fear of developing any really close contact with the group. We found upon close study that this was chiefly due to a fear of being submerged in the group. The persistence of their incapacity to adapt themselves to more normal boys and girls in time leads to their being harassed and taunted by the others, with the consequence that they are still further alienated from the group.

These children show a marked inability to stand the slightest criticism, to which they react with a total disregard of what is said to them or with vehement denials that they have the faults imputed to them. Not infrequently tears and complaints that every one "has it in for" them accompany the aggrieved self-defense. Strangely enough, the more aggressive among them show a surprising keenness in being able to detect the shortcomings of others and an only too apparent readiness in pointing them out and even exaggerating them. They do not wish to be slighted by others and will manifest great unhappiness when they are. Although insincere and unsympathetic, they cannot understand why others should ignore them.

They derive their keenest satisfactions in spheres outside the activity of the group. When they believe that it will be of benefit to them, they will work with others; otherwise they prefer to work alone. Some indulge to a marked degree in phantasy-building, others in excessive reading, and others again in wandering off by themselves. Many make use of all these methods of escape from reality, while some will confine themselves only to one or two.

All of the cases that have been studied in this group have masturbated. Excessive masturbation has occurred more

especially among those who are more secluded than the others.

Investigation of the background of these children reveals the fact that they come from environments where conflict and tension existed among the various members of the family and resulted in the breaking up of the home. These children have had a definite love object, but for some reason this has been destroyed.

In working with these children, it was soon discovered that the usual child-guidance technique was not effective. Direct and indirect suggestion, as well as modification of the environment, did not produce any fruitful results (within the limits of the institution) even after six months of effort and contact. In fact, we found that they resented our efforts to guide them and evidenced a marked desire to discontinue the relationship with us under such conditions. We were thus forced to modify our usual procedures to a considerable extent.

For the purpose of clarity, we have divided the procedure rather artificially into three periods. An absolutely definite delineation of these is impossible, since the transition from one period to another is exceedingly gradual and not easily recognizable.

The initial contacts with a child of this group are very much the same as those made with other problem children. Since every newly admitted child takes the routine psychometric tests given at the reception house of the institution, the first contact is made in this way immediately upon admission. In continuing these contacts, additional means, such as assisting the child with his work, teaching him music and the various athletic games, and helping him with minor difficulties in the school and cottage, are utilized.

Prevailing conditions at the institution make it possible to control the child's environment to a considerable extent. This has enabled us to work out a technique in continuing these contacts that differs somewhat from that used ordinarily. Because of the location of the institution (about thrity miles from New York City) frequent contacts between parent and child are as a rule exceedingly difficult. This aids in the establishment of a stronger positive transference

because it minimizes parental interference which might hinder the progress of treatment.

We feel that there is no necessity for prohibiting occasional visits from parents—in fact, we find these rather desirable. As a strong transference is established, the narcistic attachment to the parent will be weakened, but will not be entirely broken. A complete break is hazardous, in view of the fact that most of the children must eventually return to their parents.

As has already been pointed out, after the initial contact has been formed, a stage of "prolonged contact" ensues, during which the child comes to us of his own accord and begins to manifest a persistent desire for our company. As the phrase implies, this period is a drawn-out process and cannot be curtailed too soon without jeopardizing the success of the treatment that follows. The child is permitted to talk as freely as he desires on any subject that he wishes. Our attitude is a non-critical one and most often that of a listener. No suggestions or criticism are offered to the child. If he complains of any irritating factor in his environment, we again offer a willing and patient ear and do not indicate by any sign whatever that we feel that he himself is at fault. No attempts are made to lead him to talk on any particular topic nor is any special attention or interest given to any one topic. Frequently there occur various situations in the child's reactions that are in need of correction or modification. Urgent needs are given attention, but otherwise a passive attitude is assumed.

Actively we bestow as much affection on these children as is deemed necessary in the individual case. Ultimately all of them want all the affection they can possibly get, but care must be taken to give it only when it is required. Various difficulties are encountered when other children are present who also desire attention. It takes the most expert handling of these delicate situations not to antagonize the others and at the same time to make the child who requires more affection than the others feel that he is receiving the special attention he craves. We cater as much as possible to the wishes of the child, without, however, making our efforts too apparent. Success in this process can be assured only if there

is no other adult interfering—that is, by giving the child the attention and the affection he desires. Needless to say, very close coöperation on the part of the entire personnel is essential here.

It is our purpose to have the child establish a new mother or father ideal in so gradual a manner that he does not become aware of the fact that he has become attached to the person in question. It should be noted that these children have received excessive love from some one member of their family. This love has been totally devoid of a critical attitude, with the result that the social development of the child has been retarded.

Continued practice for an extended period of time of the method described, varying, of course, with the individual child, finally leads to the establishment of the desired relationship. This is an equivalent of the relationship that existed for the child at home during the early years of childhood, and it can readily be recognized by the fact that the child continually seeks the company of the worker, finding less and less need for other persons in his environment. Briefly, this stage in the therapy consists of the child's having all his love desires satisfied through the agency of one person.

The stage of actual treatment that follows may be called the "period of dependence." With our own cases, it has rarely lasted over three months. A more critical attitude toward the child's general philosophy and specific reactions to the environment is now assumed. The similarity between his reactions and those that he heretofore has criticized in others is discussed. Reasoning is utilized to make clear to him the necessity of realizing that society is rather imperfect in its organization and that all people have faults and make errors; that it is, therefore, necessary to assume an attitude of tolerance for all human defects. Situations in which he has shown undesirable reactions are carefully analyzed. We do not force too sudden changes in the beginning of this stage, but as time goes on, our criticism becomes more intensive. Toward the end of this period, the scope of discussion with the child is widened to include the more general situations met with in life. At times aspects of the child's

earlier reactions while at home are taken up, and defects inherent in the child himself are pointed out.

More general contacts are arranged for the child by drawing him into different groups. This is necessary since the child has never actually mingled with the group and must learn how to do it. Having been mentally prepared for a more social life, he will not object to joining the group and to forming closer contacts. Occasional antisocial reactions will manifest themselves, however. Attempts to rebel can be counteracted by introducing into the situation an element of humor, thus detracting from the serious aspect things may have for the child and in that way easing his irritability. At this time the child is amenable to such treatment.

Gradually, aided by the coöperation of some of the other children, the child is made to mingle more freely with the group. Having been accepted by it, he is thus given the opportunity of testing out his independence. The process that we call "weaning" must now take place. The close contact with the worker should be broken by a gradual withdrawal of some of the love. Frequently, the child, who by this time has learned to conform to acceptable social standards and may be a welcome member of the group, no longer needs us and often draws away of his own accord. In some cases, however, he resents to a marked degree these attempts at breaking his established and desired relationship. Occasionally he attaches himself to another person in an attempt to arouse our jealousy or rebel against some of our former suggestions. When such a reaction occurs, it becomes necessary to point out quite frankly to the child the great need for independence. It has been our experience that under such circumstances a child responds quickly and well. He has by this time developed a sufficient insight into his own problems and more readily understands our motive for sending him into group life.

The final step in the procedure is the natural sequence of events. Some contact, which assumes a friendship basis, is kept up with the child, and the friendly alliance continues for some time or ceases shortly, depending upon the interests of the child and the various circumstances that arise.

To illustrate the personality of these children, the tech-

nique used in modifying their reactions, and, finally, the results achieved, we have taken two rather typical cases:

Case I.—J. came under our supervision at the age of thirteen years and six months. Her intellectual status was "high average" and her progress at school normal. Physically, she was in poor condition and showed evidences of a thyroid disturbance. Her developmental history was negative.

She was born the second of five children and spent all of her life in the worst section of New York City. Both from an economic and a social point of view, the family was poorly situated and usually in great need. Her father was a ne'er-do-well who gambled away his meager earnings and quarreled constantly with his wife. The latter was neurotic to a marked degree and suffered from a thyroid disturbance (goiter). She was easily irritated and added much to the atmosphere of tension and conflict.

The parents worked as janitors and most often resided in dark, damp, filthy cellars. The home was poorly kept by the mother, whose many duties as janitress were responsible for her neglecting her own family. And finally, the father having been sent to jail several times for thievery, the family was placed in even more straitened circumstances.

J.'s father early formed an intense dislike for her and always treated her meanly, never showing her the kindness and attention that he heaped on the other children. It was felt that this was due to his identifying J. with her mother. He would discriminate against her and on the least provocation would reprimand and frequently beat her. J.'s mother, who sided with her, was feeble protection against such treatment. J. apparently returned her father's dislike and showed a marked preference for her mother. She also manifested a distinct jealousy of her sisters and could never get along with them. Her antipathy for the sister who was one and a half years her junior was especially intense.

Initial contact with J. was made by assisting her with her school work, in which she had fallen down considerably; by giving her a great deal of affection; and by permitting her to talk over her grievances for hours without any criticism. This continued for about four months without the child's becoming especially attached. She persisted in trying to make an impression by relating fantastic stories about the happy home and loving parents that she had left when she came here. Throughout this entire period, J.'s physical condition was poor; she suffered from constant headaches, and frequently fell asleep in class. It was finally considered desirable to have her tonsils removed, since they were badly diseased. Her behavior difficulties became very much exaggerated after the tonsillectomy. She sank into a deep depression and spoke continually of a desire to commit suicide and a wish to kill her sister.

At this point it was decided to institute the procedure previously outlined—*i.e.*, to subject her to that phase of our technique known as the period of "prolonged contact." For the next few months J. received this close attention. She was seen daily, and was shown a great deal of affection. A willing ear and a non-critical attitude were offered to

all of her discussions and complaints. At the same time, every possible effort was made to help her with the various school and cottage problems that arose, by obtaining the coöperation of teachers, supervisors, cottage mother, and all those who had some contact with her, so that most of the child's problems were solved for her.

After this the more intensive second stage of the therapy was begun. Her various difficulties were analyzed with her, social contacts and friendships were established for her, and a critical attitude was assumed toward her reactions in various situations. This lasted about two months, and at the end of that time J. began to show a decided change for the better. She joined a Scout group of her own volition, showed a strong desire to make friends, and made efforts to join in the various activities about her. Her phantasy-building almost entirely ceased and she began to show a willingness to face reality. She discussed her home problems frankly and made no attempt to hide any of the facts. Many of the manifestations of antisocial behavior disappeared and the girls of the group, noticing a change in her, assumed a friendlier attitude. With many more activities and a greater interest in school work, J. no longer spoke of any suicidal thoughts, assumed a more reconciled attitude toward her sister and other members of the family, and for the first time expressed a feeling of happiness and contentment.

At the present time J. has begun to break away from the worker and appears more inclined to solve her problems without outside help. Independence is being encouraged persistently. Her position in the group is more firmly established and the prognosis is good. She is gradually developing into an individual with a socially acceptable code of behavior.

Case II.—H. came under our care at the age of eleven years and six months. His intellectual status was "high average." School progress had been steady, but not of unusual achievement. Physically, the boy was in fair condition, though slightly underweight. The developmental history was normal except for enuresis, which ceased only about six months ago.

H. is the older of two children. He lived with his parents until admission to the institution. Physical conditions at home had been quite satisfactory, as the father, a buyer in the clothing industry, earned enough to support the family in comfortable fashion. However, about three years prior to H.'s coming to the Hebrew Sheltering Guardian Society, his father began to meet with reverses and soon lost all the money he had accumulated. The family was forced to move to a poorer section of the city. The stress and strain of the many changes involved seem to have been too much for the parents, who now began to quarrel constantly. The father, always a fussy and argumentative person, assumed an attitude of fault-finding toward his wife, and she, in turn, soon deserted him. Both parents tried to win H. over and each told the child of the misdoings of the other, resorting to the practice of bribing him for their own ends.

H. showed a distinct preference for his mother and would side with her on all occasions. When his mother deserted, H. refused to stay with his father. Toward his smaller brother, H. tried to act the father. However, the former, being quite a spirited and independent youngster,

resented this. They quarreled constantly, although they always made it up again and were usually together.

While in the city, H. had already begun to manifest the behavior difficulties that we later had to face at the institution. He was exceedingly disobedient and argumentative, stayed out late at night, lied, and stole a great deal. His mother made vain attempts to change the boy's attitude by accusing him of being the cause of the parental conflict, but this intensified the problem.

At the institution H. adjusted poorly. He was extremely quarrelsome and showed a marked inability to get along with any of the children. The latter, in turn, disliked him, would have nothing to do with him, and often annoyed him. He cried very easily, and it soon became a sport among his cottage mates to see how often he could be brought to tears. He could not stand criticism and always felt that people were discriminating against him. Even attempts to treat him especially well were met with the same reactions. It soon became a difficult matter to persuade the cottage mother to put up with the boy. Although not joining the group, H. made every effort to dominate it. He insisted that they do the things that he desired. He wanted to take the leading part in every conversation, and when he failed, as he invariably did, he left the group and would have nothing to do with it. In his cottage, he was the loudest and coarsest of the boys and would shout until he gained the attention he desired.

It was an easy matter to form initial contact with H. by helping him with his stamp collection and getting him out of one or two minor difficulties. From that point on much the same type of therapy was used as already described in the girl's case. He was allowed to speak freely and complain to his heart's content. Encouragement was given freely and in many ways he was helped without being made aware of the effort to help him. In time (about a year after initial contact) H. had become so dependent upon the worker that the more active therapy could be instituted.

At this point, however, interferences were encountered. One of the personnel, disregarding our suggestion, established contact with H. and began to offer him other means of getting attention and affection. When a more critical attitude was adopted toward H. by the worker, it was to be expected that he would turn to the new influence. Much valuable time was lost until the source of interference was traced and then much of the "period of prolonged contact" had to be repeated before H. was again ready for the active therapy.

Slowly the worker began to adopt a more critical attitude toward the boy. Analyses of the various difficulties into which he got himself were made. The more tolerant approach to human problems was pointed out to him and the necessity of learning to mingle with others was emphasized. At the same time, several other children were asked to cooperate with the worker in taking the boy into group play. This was successful and H. gained an entrance into the group. In the three months for which this period lasted, a marked change took place in the boy. He learned to take criticism and to act on it and at the same time became more tolerant of the faults in others. He also learned to regard himself more objectively and to correct his own deficiences. With such changes, the group after a time accepted him as one of them and even

put up with a number of remaining personality defects that still persisted to some extent.

Weaning was a more difficult process in this case, H. showing a disinclination for breaking away from the worker. However, when it was made clear that a healthy development of himself depended on it, the boy grew less resentful and made more effort to become independent.

At the present time, H. is still with us, but is showing himself to be a much better adjusted individual than ever before. In fact, one could not distinguish him from any of the other children in a group that are essentially normal. He is showing an increasing ability to form new friendships, and is happy in his knowledge that he can care for himself. Toward the home situation, he has adopted a more objective attitude and realizes that he was not to blame for the parental conflict.

Little remains to be added to the procedure outlined for the treatment of the type of personality that we have described. The children who have been treated by this technique have ranged in age from about ten to fifteen years and have varied from average to superior intelligence. Children of retarded mental development do not lend themselves very well to this type of treatment. Their inability to follow the reasoning when various situations are analyzed with them makes it impossible to utilize the method described.

Therapy as we have indicated it actually depends upon accepting the child at the low emotional-age level at which he is first found, establishing an ideal for him, and then, through this ideal, stimulating him to a more rapid growth toward a higher emotional age.

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RESEARCH INVITES THE PSYCHIATRIC SOCIAL WORKER

INA L. MORGAN

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THE history of progress is a history of research. The pioneers of scientific research were the Greek intellectuals, who charted unknown seas with primitive theories in the era when the only sciences in existence were mathematics, mechanics, and limited studies in anatomy. Each subsequent century has given birth to new sciences, new professions, new schools of art, and new fields of industry, which in turn have been subject to an ever-increasing classification. As we thoughtfully consider the history of progress, we find the development, advance, and integration of the arts and sciences to be commensurate with the research conducted in their respective fields.

In the science of medicine, the earliest endeavors of profound research are credited to Hippocrates, 300 B.C., who is called the Father of Medical Art. He advanced a theory regarding the treatment of disease which relied upon the forces of nature, combined with the power of the body itself, aided by proper regimen and helpful environment, in eliminating and overcoming even serious disorders. More important than the truth that this theory has never been superseded is the fact that the candlelight of Hippocrates' research efforts was the gleam which led other physicians into the wilderness of disease causation. The research of the centuries has not only established long-distance beacon lights of prevention, but high-powered searchlights which some of our specialized physicians of to-day are eagerly following in the never-ending search for knowledge and techniques that will overcome the devastating power of disease.

The marvelous inventions, stupendous undertakings, and colossal organizations of the twentieth century are so dazzling that we are prone to look upon them as emanating from a

scientific Aladdin's lamp, as it were. We do not give sufficient thought to the indefatigable research activities of the preceding centuries, which have made possible the scientific wonders of the present day.

It is not enough to honor only the research workers who are universally known because of the magnitude and importance of their achievements. We must pay homage to the multitude who have never been known beyond the narrow confines of their environment. These men and women just as truly spent and were spent to the fullness of their ability, and unquestionably not only made valuable contributions in the fields of their endeavors, but emphasized the eternal values of the research process.

Having tried to indicate briefly that research is the fundamental basis of progress, we may be asked just what we mean by research. It is our opinion that the descriptive language used by the persons who are active in a given work is the best medium of interpretation. Therefore, we are quoting from a wide range of research workers who are recognized authorities in their chosen fields. Research is "accelerated experience," "seeking something new," "a state of mind," "the answer determined by scientific methods to the question, Why?" "simply an exploration, a systematized search." "Research is not the obtaining of additional data regarding what is already known; it is the exploring the unknown for generic facts or principles. It seeks the new knowledge which makes new things possible." "It is awareness of error as well as of new things." "Social research is a study of social processes, also a way of making people mutually understood." "Social research seeks to define social problems." "The principle of exploration is the Alpha and Omega of social research."

We now have a general background and perspective for considering the specific field of research with which we are concerned at the present time. In choosing the field of psychiatric social work for our subject, we are by no means ignoring social work in its entirety. Neither do we seek to place any undue emphasis upon this particular field of social work. We are deeply concerned with psychiatric social work because it is a comparatively new field in a state of transition

and not clearly established in its position relative to social work as a whole.

The objective of each process of research lies within a limited field of its own and is determined by its substance. For example, the objective of mathematical research is bounded by quantities, form, number, and motions, all of which are encircled by exactness. In the process of biological research we must follow the course blazed by evolution. If we would do research in the art of music, we must "staff" our objective within the lines and spaces of rhythm, melody, or harmony, and have as the determining factor the system of notation.

Research in the field of social work must have an objective that can be translated into terms of human life and its relationships. Instead of electrons, architectural design, and the like, we are restricted to a world of individuals in a social order. These individuals have inherited "the tradition of the elders" as their birthright; society has institutionalized them, theories have possessed them, and ideals lured them. Predominating over all these factors is a controlling law directing the process as a whole which Cooley calls "adaptive growth."

In psychiatric social work, our attention is directed to a large group of individuals who are not subservient to this law of "adaptive growth." This condition is not necessarily due to a deliberate choice on the part of the individual. It may be due to a pathological or environmental cause. Whatever the causes, they cannot be dealt with *en masse,* but must be understood and treated individually. This condition is not an arbitrary one, so far as social adjustment is concerned.

The purpose of psychiatric social work is to recognize and interpret the social difficulties incident to "adaptive growth" and, under the direction of a psychiatrist, to treat the individual by directing him toward the attainment of the fullest social growth and adjustment possible to him. It is of great importance to recognize and respect the limits of each personality. Much earnest and honest effort has been wasted and discouragement caused by social workers who have persistently tried over long periods of time to develop socially unadjusted individuals beyond their capacities. The psychiatric social worker may rightfully be called a social pathologist.

Psychiatric social treatment cannot be successfully conducted without a comprehensive understanding of the patient's personality as a whole. This is possible in the degree to which we have accurate knowledge regarding the social heritage, environment, emotional and intellectual content, behavior, and social and economic adaptation of the individual; also his relative social status in any or all periods of his existence.

The most important and effective tool or medium as yet found for securing this knowledge is the psychiatric social history. This history is far more than a chronological presentation of the individual's development and personality trends. It indicates the social forces or combination of forces that have controlled or swayed the personality in its "adaptive growth." It also provides clues for determining the probable substitutions that the individual has made in his efforts, or his inability, to accept and adjust to reality. It is, too, the most effective instrument in the application of this knowledge that has been obtained. The most comprehensive social-psychological information of the individual is of little, if any, value unless it is used to assist him through his difficulties.

Let us advance one step nearer our objective. The psychiatric social history is the threshold of research in the field of psychiatric social work. The most recent example of the social history as a research technique, requiring the utmost skill in its fashioning and use, is the study reported by Sheldon and Eleanor Glueck in *500 Criminal Careers*. A few quotations will make clear our meaning: "The present contribution is based upon careful investigation into the life histories of all prisoners released from the Massachusetts Reformatory whose sentences expired in 1921—namely, 510 . . . a very elaborate and careful technique had to be worked out in order to obtain complete and reliable data, not only as to the careers and background of our offenders before they entered the Reformatory, but regarding the criminal and social history during parole and after. Without such a thoroughgoing investigation, this work would have been impossible. Research and experiments are the basic needs. . . . We must now turn our finest resources of heart and mind to the solution of the problem of social pathology. . . .

Hundreds of life histories . . . might be sketched. They are all similar and all different. . . . The points of difference, of uniqueness in the individual case cannot be safely determined without a careful evaluation of that case in the light of the points of similarity of hundreds of other cases."

We sincerely believe that some of the "finest resources of heart and mind" are to be found in the young graduates from our schools of social work. These graduates have met recognized standards of education and received intensive training under careful supervision. Their ideals are high and the opportunities for achievement that lie before them are intriguing. As these adequately trained workers enter psychiatric social work, they have a right to expect a profession in which the scientific spirit prevails, progress is the dominant note, and research is the lodestar.

We desire to present psychiatric social work as one of the most interesting, exacting, and fruitful fields of research. It deals with life in the living, personality in its development, and adjustment in the very process of adjusting. Action and reaction are constantly finessing for supremacy. Everywhere in this field of personality maladjustment, there is an intangible surging, shifting, striving effort to find a harbor of security. Could there be a more stimulating, inspiring, and productive research than the endeavor to "seek out the origin of the 'different' in personal experiences, penetrate to the ultimate human sources of knowledge, uncover the beginnings of misunderstanding, and open the way for accommodation and the peaceful adjustments of conflicts, not to mention the possibility of preventing misunderstanding and strife"?

The results of research have no relation to magic, even though they are more amazing than the art of the cleverest conjurer. Research must be translated in terms of hard, long, patient toil, constant alertness, keen observation, accurate recording, well-balanced judgment, and demonstrable conclusions. Because research is such a process and its results cannot be known or made helpful overnight, it seems important to emphasize the need and value of research in the early stages of this immature field of social work, that its development and advance may be assured.

What type of personality is best qualified to navigate the sea of research? A careful personality study of successful research workers fails to disclose any specific type that can be labeled a "search personality." We do find, however, that certain personality traits or characteristics pertain to the majority. With practically no exception, we find a wide horizon of thought and a vision that extends far beyond the day's work; also, ability to appreciate the importance of the work, and at the same time to recognize its significance in relation to other spheres of endeavor rather than as an end in itself. Many research workers are good students, able to recognize and define a problem and eager to attempt its solution. Patience and thoroughness in obtaining information are outstanding traits, as is also exactness in the presentation of facts. The characteristic of inquisitiveness is preëminent. Some one has said of an eminent research worker, "He was always anxious to know why 'a' is so and 'b' is not." In place of the traditional "three R's" of education, we may substitute in research three P's—Perseverance, Persistence, Precision. As we search for more intimate traits, we find open-mindedness, tolerance, generosity, simplicity, and common sense predominating; also the desire to encourage other workers and the ability to applaud their successes.

The slogan, "Every psychiatric social worker a research worker," is hardly practicable, but we may to great advantage adopt the slogan, "Never be content with the obvious." The obvious is the threshold to an enchanted world. Through refusal to be content with the obvious, we believe, research objectives would not only become more apparent, but new information would be gleaned by many workers. Furthermore, some of the finest minds would be induced to explore the great unknown to discover and interpret new facts and principles, and to devise new methods applicable to this field.

While our chief concern is for the individual worker, who is the substratum of every structure, we cannot conclude this article without stressing the need for leaders. We need leaders of vision, with wide horizons, leaders who are able to inspire the workers, leaders who will correlate the work as a whole and determine vital objectives. We need leaders

who are thoughtful and who can interpret psychiatric social work in terms of practical principles and wide usefulness; also leaders who have the ability to encourage others and to applaud when they, too, succeed. Only leadership of such caliber will inspire psychiatric social workers to blaze a trail of research through the dark forests of human experience to the heights of triumphant living for the multitude who otherwise would sink in the mire of despair and desolation.

LIFE TABLES FOR PATIENTS WITH MENTAL DISEASE *

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MENTAL diseases are often the direct consequences of physical processes, as in general paralysis. In other cases, there is an association of physical and mental elements, even though the relation may not be one of cause and effect. It is also true, however, that the mental condition is in itself an important factor in the morbidity and mortality of patients with mental disease. An obvious illustration of this is seen in the exhaustion that so often results from prolonged periods of excitement in the manic-depressive psychoses. There are also indirect results consequent upon bad personal attitudes toward health, such as the marked indifference of dementia-praecox patients to the need of exercise and their lack of attention to matters of personal hygiene. For these reasons one would anticipate higher rates of mortality among the mentally diseased. Indeed, as measured in the usual manner, the death rate among patients with mental disease appears to be seven or eight times higher than that among the general population.

Since the proportion of the population suffering from mental disease has increased rapidly in recent decades, the higher rates of mortality among the insane population must have had an unfavorable effect upon the general mortality rates. It is well known, for example, that the increase in the expectation of life has not been manifested equally throughout the life span. Thus, whereas the expectation of life at birth among males in the state of New York increased from 45.6 years in 1901 to 52.8 years in 1920, an increase of 15.8 per cent, the corresponding expectations at age twenty-two were 38.6 and 41.4 years, respectively, an increase of only 7.2 per cent. At age thirty-two, the expectation of life increased 6.8 per

* Read at the Ninety-third Annual Meeting of the American Statistical Association, Washington, D. C., December 30, 1931. Reprinted from the *Psychiatric Quarterly*, April, 1932.

cent during the same interval; at age fifty-seven, the increase amounted to only 3.2 per cent; and at age sixty-two, to only 0.9 per cent. Beyond this age to the end of the life span, the expectation of life actually decreased during the period from 1901 to 1920. The results for females are in general the same as for males. These facts are well known, and constitute one of the anomalies in public health. For whereas the control of infant and child diseases and the great decline in tuberculosis and other zymotic diseases have lowered death rates throughout the earlier part of the life span, the result has been to increase the effects of the so-called degenerative diseases at later ages. Increased death rates resulting from circulatory diseases, nephritis, and cancer have received close study, but until recently it had not been sufficiently noted that mental diseases are very closely associated with morbidity and mortality in the advanced age periods. The rate of mental disease increases very rapidly with age, especially past middle life. Consequently, by increasing the expectation of life in the lower half of the life span, we add to the number who will become mentally diseased in the later years of life. When to the great number of patients with mental disease under treatment in hospitals we add the unknown, though undoubtedly significant, total of the mentally ill outside of hospitals, it is apparent that their differential rates of mortality must be considered as contributory factors in the general mortality. In this study, therefore, we shall attempt to measure, as accurately as the available data permit, the rates of mortality and the expectation of life among patients with mental disease, limiting the analysis necessarily to an institutional population, since there are no similar data relative to the non-institutional insane.

The primary statistical problem is concerned with the index of the rate of mortality. Several measures have been in use. One related the deaths to the population in the institution at the beginning of the year. Another used the total number of patients under treatment during the year as the equivalent of the total annual exposures. Both methods have been criticized in recent reports dealing with mental patients in state hospitals, issued by the Bureau of the Census.[1] It

[1] See, for example, *Mental Patients in State Hospitals, 1926 and 1927*, p. 28.

was pointed out that the use of the population at the beginning of the year results in an underestimation of the number of annual exposures, and consequently increases the death rate. By using the total number under treatment during the year, on the other hand, we overestimate the annual exposures, thereby decreasing the death rate. Furthermore, the total under treatment depends upon the rate of turnover. A rapid turnover would increase the total under treatment, and would, therefore, tend to decrease the death rate. On the other hand, the number of deaths is markedly influenced by the presence of the acute cases among admissions. A high admission rate, consequently, would tend to increase the death rate, thus further complicating the problem of finding a satisfactory measure of the rate of mortality.

If we were enabled to follow a large population of first admissions with mental disease through life, we could obtain correct rates of mortality as follows: Suppose we began with a population of 100,000, all aged exactly twenty years. If we traced the histories until all had died, we would have the total deaths in the age group twenty during the first year of exposure, the total in the second year occurring at age twenty-one, and so forth, to the end of the generation. The ratio of the deaths in a year in any age group to the population alive at that age at the beginning of the year would represent the exact rate of mortality at that age. In practice, it is impossible to obtain such a record, even in the case of a normal population. The situation is complicated still further, in the case of the insane, by the fact that the same group is not under continuous observation for even a single year. Some of those present at the beginning of the year are discharged in the course of the year; those admitted during the year are under exposure for varying parts of the year. It is, therefore, necessary to arrive at an indirect measure of the number of *annual* exposures which, in conjunction with the number of deaths, will give the rate of mortality.

In its recent publications[1] the Bureau of the Census has determined the equivalent number of full-time patients by use of the formula $T = P + \frac{1}{2}(A - D)$, where P represents the number of patients present at the beginning of the year,

[1] *Op. cit.*, p. 27.

A the number of admissions, and D the number of discharges during the year. This is based upon the theory that the patients present at the beginning of the year remain for the entire year, except for the discharges from that group, and that the admissions and discharges are present, on the average, six months. The assumption that each discharge has an average exposure of six months is a very doubtful one, and probably results in reducing slightly the total of full-time patients, thereby exaggerating the mortality rate. In any event it would be impossible to apply the formula directly to the present study, owing to the fact that detailed statistics of this type are not available for individual ages. If, however, we assume that the error is slight—as it probably is—and that the hospital population increases in the course of the year in accordance with a linear trend (an assumption that is very justifiable) then we may adjust the preceding formula so as to obtain the hospital population at the middle of the year.[1] The theoretical value thus obtained should agree with the observed population at the middle of the year. This is the basic assumption that we have utilized in determining the population at each age level.

This study is based on a total of 12,599 deaths in the New York civil state hospitals, of whom 6,433 were males and 6,166 females, the deaths occurring during the three fiscal years beginning July 1, 1928, and ending June 30, 1931. The age distribution of the resident population was taken as of April 1, 1930, the date of the general Federal census of population, each of the New York civil state hospitals submitting a schedule to the statistical bureau of the state department of mental hygiene for each resident patient. For our calculations we required the resident population at the middle of the fiscal year 1929–1930—namely, on January 1, 1930. This was available for the total resident population, but the latter was not distributed according to age. This was obtained on the assumption that the age distribution on January 1, 1930, was relatively the same as that shown by the

[1] For let P' = the population at the end of the year, and P'' the population at the middle of the year. $P' = P + A - D - d$, where d is the number of deaths. In an arithmetic progression,

$$P'' = \frac{P + P'}{2} = \frac{P + P + A - D - d}{2} = P + \frac{1}{2}(A - D) - \frac{d}{2} = T - \frac{d}{2}$$

census on April 1, 1930. As only three months had elapsed, it is hardly possible that any significant change could have occurred in the age constitution of the resident population. On January 1, 1930, there were 22,030 males and 24,295 females resident in the state hospitals.

Both the population and the deaths were grouped into quinquennial age intervals, beginning with a group aged five to nine years. Pivotal central values were obtained at ages seventeen, twenty-two, twenty-seven, and so forth, and corresponding rates of mortality were computed in the usual manner from the formula $q_x = \frac{2\,m_x}{2 + m_x}$ where q_x is the rate of mortality at age x and m_x the central death rate. The mortality rates at intervening years were obtained by osculatory interpolation, the procedure being that adopted by Mr. George King, the English actuary, and illustrated by him in his report on life tables, issued as a supplement to the Seventy-fifth Annual Report of the Registrar-General of Births, Deaths, and Marriages in England and Wales.

Owing to the small numbers involved, the rates of mortality under seventeen years of age can hardly be considered reliable, and it was, therefore, deemed advisable to begin the life tables at age twenty. Toward the close of the life span, the rates are again unreliable, especially for males, because of the few cases involved, and possibly because of errors in the reporting of age. But the effect on the expectation of life can hardly be serious, up to at least seventy-five years of age, since the heavy mortality in the preceding years will have reduced the life-table populations to such small totals that the subsequent errors, if any, in the number of expected deaths at ages seventy-five and over could not affect the preceding values significantly.

The rates of mortality are summarized in Table I, and are shown graphically in Chart I.

Among male patients with mental disease the rate of mortality is 48.02 per 1,000 at twenty years of age. The rate then declines for a series of years, reaching a minimum of 35.49 at twenty-eight years of age. Thereafter the rate increases steadily through each interval to a rate of 494.04 at

eighty-seven years of age. Female patients, interestingly enough, have a higher rate of mortality than males at the younger ages. They begin with a rate of 57.37 at twenty years of age, compared with a rate of 48.02 among males. The rate among females then declines, as in the case of the males, to a minimum of 40.63 at age thirty-six. At thirty-five

TABLE I.—RATES OF MORTALITY PER 1,000 POPULATION

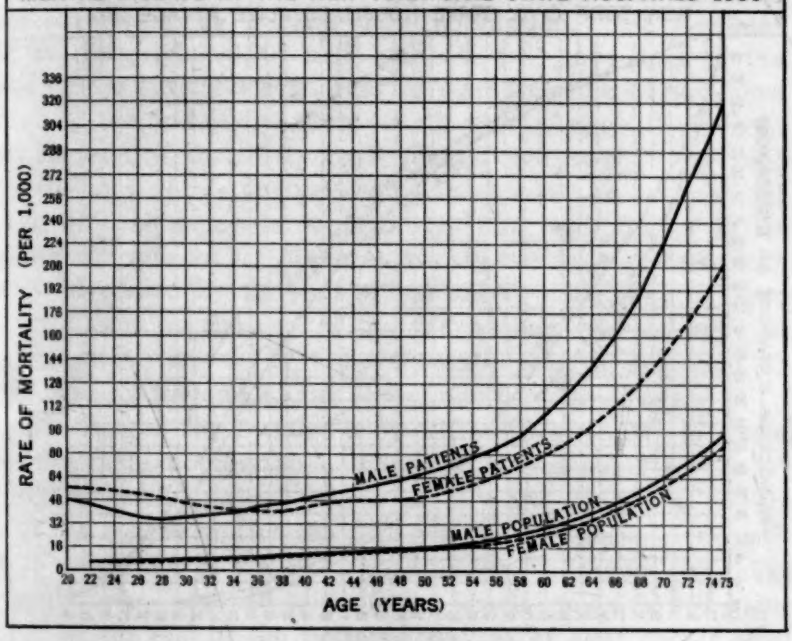
Age (years)	*Patients with mental disease, 1930*		*Population of state of New York, 1920*	
	Males	Females	Males	Females
22	45.51	55.78	5.38	5.28
27	35.82	51.02	6.27	6.60
32	38.26	42.51	7.39	6.74
37	43.82	40.80	8.41	6.73
42	52.13	45.35	10.04	8.11
47	59.56	47.83	12.69	10.66
52	72.77	54.99	17.11	14.40
57	88.92	68.49	24.83	21.42
62	113.92	90.20	34.53	29.64
67	171.58	122.08	50.09	46.70
72	267.28	171.86	73.08	69.40
77	337.95	241.47	105.93	98.63
82	436.50	334.23	156.03	140.30
87	494.04	450.14	206.86	199.05

years of age, the rate among males exceeds that of the females for the first time, and from that point to the end of the life span, the female mortality rate, though it rises steadily, is much lower than that of the males. For the purpose of comparison, we have introduced the mortality rates for males and females in the state of New York in 1920, this being the latest available data for New York. The rates among patients are so much higher as to necessitate no detailed comment.

Certain elements should be noted in connection with the mortality rates among patients with mental disease. In the first place, the resident population is reduced in the course of the year by the paroling of patients, who represent a group selected because of a favorable prognosis. It is unlikely that many deaths occur among paroles. Consequently, if this group had been included in the total exposures for the year, the mortality rates would have been reduced accordingly. On the other hand, the resident population also represents a

selection. It consists primarily of the accumulation of old and chronic cases, among whom there are relatively few deaths, compared with the great number that occur among the admissions, who represent acute cases. The number of expected deaths in the hospital population is, therefore, greatly reduced. This more than counterbalances the un-

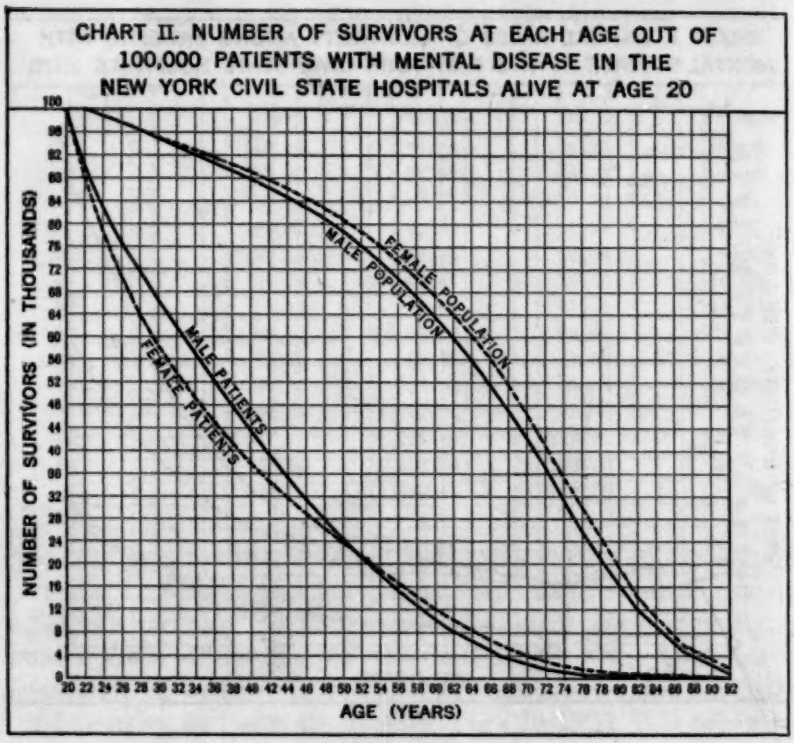
CHART I. ANNUAL RATES OF MORTALITY AMONG PATIENTS WITH MENTAL DISEASE IN THE NEW YORK CIVIL STATE HOSPITALS 1930



favorable effect on mortality rates resulting from the use of parole. We may, therefore, feel confident that the high rates of mortality are not statistical exaggerations. The differances in mortality rates in a group of first admissions and in a relatively stabilized resident population must be insisted upon. For if, as suggested earlier, we could have begun our analysis with a large group of first admissions, all of the same age, the presence of the great number of acute cases among them would inevitably increase their mortality rates during the early years, as compared with those shown in the present study.

We should also note the contrasting pictures shown by

the two sets of curves on Chart I. Whereas, in the general population, the death rate of the males constantly exceeds that of the females, in the case of the patients with mental disease the female death rates are in excess up to the thirty-fourth year. Again, the mortality rates in the general population rise steadily from twenty years of age to the end of



the life span, but the rates among the patients decline for several years after twenty years of age, the period of decline being of longer duration in the case of the females. This may be adequately explained by the nature of the distribution of the populations according to psychoses. Thus the death rates at the younger ages are greatly influenced by the presence of patients with manic-depressive psychoses, in which the attacks tend to be acute rather than chronic and the death rates relatively high. The females greatly exceed the males among the manic-depressives, both among admissions and among resident patients. This, therefore, tends to in-

crease their death rates, and it is not until the other psychoses begin to be represented in the population in significant numbers that the trend changes.

Another method of measuring mortality is to consider the numbers that die within stated age intervals. Of our assumed group of 100,000 male patients aged exactly twenty years, 20,522 will die within the first five years of exposure. According to the Foudray abridged life table for males in the state of New York in 1919–1920, only 2,841 deaths will occur in the corresponding general male population. Ten per cent of the original 100,000 male patients will have died by the end of the twenty-second year of age; 25 per cent will have died by the end of the twenty-sixth year of age; 50 per cent by the end of the thirty-sixth year of age; and 75 per cent by the end of the forty-ninth year of age. In the general male life-table population in 1919–1920, beginning with an assumed group of 100,000 aged twenty-two years, 10 per cent will have died by the end of the thirty-sixth year of age; 25 per cent by the end of the fifty-second year of age; 50 per cent by the end of the sixty-sixth year of age; and 75 per cent by the end of the seventy-sixth year of age.

The results for females show differences similar to those in the male populations. Thus, of the assumed group of 100,000 female patients aged exactly twenty years, 25,010 will die by the end of the fifth year of exposure, compared with only 2,899 in the corresponding general female life-table population. Ten per cent of the female patients will have died by the end of the twenty-first year of age; 25 per cent by the end of the twenty-fourth year of age; 50 per cent by the end of the thirty-third year of age; and 75 per cent by the end of the forty-eighth year of age. In the corresponding general female life-table population in 1919–1920, beginning with an assumed group of 100,000 aged twenty-two years, 10 per cent will have died by the end of the thirty-eighth year of age; 25 per cent by the end of the fifty-fourth year of age; 50 per cent by the end of the sixty-eighth year of age; and 75 per cent by the end of the seventy-seventh year of age. By reference to Chart II, it will be noted that among the survivors in the general population, the females exceed the males in number, practically throughout the life span.

In the case of the survivors among the patients, the males are in excess up to the fifty-third year, the females exceeding the males thereafter. This is due to the heavier mortality of the females at the younger ages.

The values for the expectations of life are summarized in Table II, and are shown graphically in Chart III.

TABLE II.—EXPECTATION OF LIFE (IN YEARS)

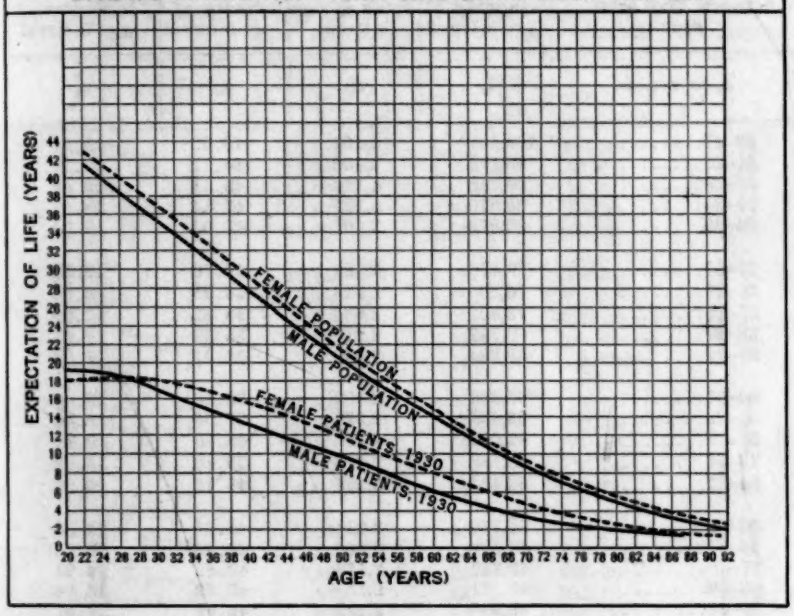
Age (years)	*Patients with mental disease, 1930*		*Population of state of New York, 1920*	
	Males	Females	Males	Females
22	19.02	18.18	41.40	42.98
27	17.96	18.28	37.54	39.19
32	16.10	17.67	33.74	35.44
37	14.21	16.26	29.98	31.57
42	12.40	14.61	26.25	27.63
47	10.67	12.86	22.59	23.79
52	8.92	10.92	19.08	20.11
57	7.17	8.97	15.83	16.68
62	5.46	7.16	12.88	13.52
67	3.98	5.53	10.22	10.71
72	2.84	4.15	7.94	8.40
77	2.21	3.02	6.00	6.48
82	1.75	2.21	4.38	4.85
87	1.48	1.60	3.07	3.50

For the male patients, the expectation of life at age twenty is 19.17 years, and decreases steadily thereafter to a minimum of 1.48 at age eighty-seven. For females, the expectation of life is 18.06 years at twenty years of age, which is 1.11 years less than that for the males at the same age. The expectation decreases to a minimum of 1.22 years at ninety-one years of age. The expectation of life is lower among females than among males until twenty-six years of age, when the expectations are 18.30 and 18.25 years for females and males respectively. From this year to the end of the life span, the females have a higher expectation of life. The lower expectation of life among females in the earlier years is a consequence of their greater mortality during these years, as previously indicated.

These expectations among patients with mental disease may be compared with those among the general population of New York State, as computed by Miss Foudray for 1919–20. At age twenty-two, the males had an expectation of 41.40

years, the females of 42.98 years, as compared with 19.02 and 18.18 years for male and female patients respectively. At every age the general population has an expectation of life from two to three times as great as that among the patient population. Whereas the male patients have a greater expectation of life than the females at the earlier years, in

CHART III. EXPECTATION OF LIFE OF PATIENTS WITH MENTAL DISEASE IN THE NEW YORK CIVIL STATE HOSPITALS 1930



the general population the females have a higher expectation of life at all years. It is also important to note that among the general population, the span of life is estimated at about one hundred and five years, whereas among patients with mental disease the heavy mortality results in the male population's disappearing at eighty-seven years, and the female at ninety-one, an extremely significant reduction in the life span.

Our results may now be summarized as follows:

1. The rates of mortality at corresponding ages are from three to six times as great among patients with mental disease as among the general population.

2. The higher rates of mortality result in a very rapid

TABLE III.—LIFE TABLE FOR MALE PATIENTS IN THE NEW YORK CIVIL STATE HOSPITALS, 1930

Age interval (years)	*Of 100,000 male patients alive at age 20*		*Annual rate of mortality per thousand*	*Expectation of life (years)*
Period of lifetime between two exact ages	*Number alive at beginning of age interval*	*Number dying in age interval*	*Number dying in age interval among 1,000 alive at beginning of age interval*	*Average length of life remaining to each one alive at beginning of age interval*
x to $x+1$	l_x	d_x	q_x	$\mathring{e}_x$
20–21.....	100,000	4,802	48.02	19.17
21–22.....	95,198	4,452	46.77	19.11
22–23.....	90,746	4,130	45.51	19.02
23–24.....	86,616	3,737	43.14	18.91
24–25.....	82,879	3,401	41.04	18.74
25–26.....	79,478	3,128	39.36	18.52
26–27.....	76,350	2,923	38.28	18.25
27–28.....	73,427	2,630	35.82	17.96
28–29.....	70,797	2,513	35.49	17.61
29–30.....	68,284	2,443	35.77	17.24
30–31.....	65,841	2,402	36.48	16.86
31–32.....	63,439	2,371	37.38	16.48
32–33.....	61,068	2,336	38.26	16.10
33–34.....	58,732	2,298	39.12	15.72
34–35.....	56,434	2,264	40.12	15.34
35–36.....	54,170	2,234	41.24	14.96
36–37.....	51,936	2,206	42.48	14.58
37–38.....	49,730	2,179	43.82	14.21
38–39.....	47,551	2,155	45.32	13.84
39–40.....	45,396	2,133	46.99	13.47
40–41.....	43,263	2,109	48.74	13.11
41–42.....	41,154	2,077	50.48	12.75
42–43.....	39,077	2,037	52.13	12.40
43–44.....	37,040	1,985	53.58	12.06
44–45.....	35,055	1,927	54.96	11.71
45–46.....	33,128	1,869	56.43	11.37
46–47.....	31,259	1,818	58.15	11.02
47–48.....	29,441	1,754	59.56	10.67
48–49.....	27,687	1,711	61.79	10.31
49–50.....	25,976	1,670	64.29	9.96
50–51.....	24,306	1,629	67.00	9.61
51–52.....	22,677	1,584	69.85	9.26
52–53.....	21,093	1,535	72.77	8.92
53–54.....	19,558	1,473	75.31	8.58
54–55.....	18,085	1,402	77.51	8.24

TABLE III (CONCLUDED).—LIFE TABLE FOR MALE PATIENTS IN THE NEW YORK CIVIL STATE HOSPITALS, 1930

Age interval (years)	*Of 100,000 male patients alive at age 20*		*Annual rate of mortality per thousand*	*Expectation of life (years)*
Period of lifetime between two exact ages	*Number alive at beginning of age interval*	*Number dying in age interval*	*Number dying in age interval among 1,000 alive at beginning of age interval*	*Average length of life remaining to each one alive at beginning of age interval*
x to $x+1$	l_x	d_x	q_x	$\mathring{e}_x$
55–56.....	16,683	1,336	80.06	7.89
56–57.....	15,347	1,284	83.64	7.53
57–58.....	14,063	1,250	88.92	7.17
58–59.....	12,813	1,206	94.16	6.82
59–60.....	11,607	1,162	100.08	6.48
60–61.....	10,445	1,141	106.67	6.14
61–62.....	9,304	1,060	113.92	5.78
62–63.....	8,244	1,005	121.85	5.46
63–64.....	7,239	944	130.46	5.15
64–65.....	6,295	880	139.73	4.85
65–66.....	5,415	810	149.67	4.55
66–67.....	4,605	738	160.28	4.26
67–68.....	3,867	663	171.58	3.98
68–69.....	3,204	600	187.24	3.70
69–70.....	2,604	538	206.70	3.44
70–71.....	2,066	471	227.90	3.21
71–72.....	1,595	397	248.77	3.01
72–73.....	1,198	320	267.28	2.84
73–74.....	878	248	282.65	2.69
74–75.....	630	189	299.79	2.54
75–76.....	441	141	319.84	2.42
76–77.....	300	99	328.90	2.32
77–78.....	201	68	337.95	2.21
78–79.....	133	48	357.31	2.09
79–80.....	85	32	380.05	1.97
80–81.....	53	21	402.47	1.88
81–82.....	32	13	420.88	1.80
82–83.....	19	8	431.58	1.75
83–84.....	11	5	436.54	1.70
84–85.....	6	3	454.74	1.63
85–86.....	3	1	467.82	1.58
86–87.....	2	1	481.12	1.53
87–88.....	1	1	494.04	1.48

TABLE IV.—LIFE TABLE FOR FEMALE PATIENTS IN THE NEW YORK CIVIL STATE HOSPITALS, 1930.

Age interval (years)	*Of 100,000 female patients alive at age 20*		*Annual rate of mortality per thousand*	*Expectation of life (years)*
Period of lifetime between two exact ages	*Number alive at beginning of age interval*	*Number dying in age interval*	*Number dying in age interval among 1,000 alive at beginning of age interval*	*Average length of life remaining to each one alive at beginning of age interval*
x to $x+1$	l_x	d_x	q_x	$\mathring{e}_x$
20–21.....	100,000	5,737	57.37	18.06
21–22.....	94,263	5,323	56.47	18.13
22–23.....	88,940	4,961	55.78	18.18
23–24.....	83,979	4,654	55.42	18.23
24–25.....	79,325	4,335	54.65	18.27
25–26.....	74,990	4,019	53.59	18.29
26–27.....	70,971	3,715	52.34	18.30
27–28.....	67,256	3,431	51.02	18.28
28–29.....	63,825	3,156	49.45	18.24
29–30.....	60,669	2,885	47.56	18.16
30–31.....	57,784	2,635	45.60	18.04
31–32.....	55,149	2,397	43.46	17.88
32–33.....	52,752	2,242	42.51	17.67
33–34.....	50,510	2,103	41.63	17.44
34–35.....	48,407	1,987	41.04	17.17
35–36.....	46,420	1,890	40.71	16.89
36–37.....	44,530	1,809	40.63	16.58
37–38.....	42,721	1,743	40.80	16.26
38–39.....	40,978	1,694	41.34	15.93
39–40.....	39,284	1,661	42.27	15.60
40–41.....	37,623	1,632	43.38	15.26
41–42.....	35,991	1,601	44.47	14.93
42–43.....	34,390	1,560	45.35	14.61
43–44.....	32,830	1,507	45.90	14.28
44–45.....	31,323	1,449	46.26	13.94
45–46.....	29,874	1,392	46.60	13.59
46–47.....	28,482	1,341	47.07	13.23
47–48.....	27,141	1,298	47.83	12.86
48–49.....	25,843	1,263	48.86	12.48
49–50.....	24,580	1,230	50.05	12.09
50–51.....	23,350	1,201	51.45	11.71
51–52.....	22,149	1,176	53.08	11.31
52–53.....	20,973	1,153	54.99	10.92
53–54.....	19,820	1,133	57.15	10.53
54–55.....	18,687	1,113	59.54	10.13

TABLE IV (CONCLUDED).—LIFE TABLE FOR FEMALE PATIENTS IN THE NEW YORK CIVIL STATE HOSPITALS, 1930

Age interval (years)	*Of 100,000 female patients alive at age 20*		*Annual rate of mortality per thousand*	*Expectation of life (years)*
Period of lifetime between two exact ages	*Number alive at beginning of age interval*	*Number dying in age interval*	*Number dying in age interval among 1,000 alive at beginning of age interval*	*Average length of life remaining to each one alive at beginning of age interval*
x to $x+1$	l_x	d_x	q_x	$\mathring{e}_x$
55–56.....	17,574	1,093	62.19	9.74
56–57.....	16,481	1,074	65.16	9.36
57–58.....	15,407	1,055	68.49	8.97
58–59.....	14,352	1,035	72.14	8.60
59–60.....	13,317	1,013	76.09	8.23
60–61.....	12,304	989	80.39	7.86
61–62.....	11,315	963	85.08	7.51
62–63.....	10,352	934	90.20	7.16
63–64.....	9,418	901	95.64	6.82
64–65.....	8,517	863	101.36	6.49
65–66.....	7,654	823	107.55	6.16
66–67.....	6,831	781	114.39	5.84
67–68.....	6,050	739	122.08	5.53
68–69.....	5,311	693	130.56	5.23
69–70.....	4,618	646	139.80	4.94
70–71.....	3,972	595	149.83	4.67
71–72.....	3,377	543	160.71	4.40
72–73.....	2,834	487	171.86	4.15
73–74.....	2,347	432	184.14	3.90
74–75.....	1,915	378	197.17	3.67
75–76.....	1,537	324	210.85	3.44
76–77.....	1,213	273	225.12	3.23
77–78.....	940	227	241.47	3.02
78–79.....	713	185	259.88	2.83
79–80.....	528	148	280.93	2.64
80–81.....	380	115	302.05	2.48
81–82.....	265	85	320.67	2.34
82–83.....	180	60	334.23	2.21
83–84.....	120	43	355.56	2.08
84–85.....	77	29	377.82	1.94
85–86.....	48	19	401.00	1.82
86–87.....	29	12	425.11	1.71
87–88.....	17	8	450.14	1.60
88–89.....	9	4	476.10	1.49
89–90.....	5	3	502.99	1.40
90–91.....	2	1	530.80	1.31
91–92.....	1	1	559.54	1.22

reduction in the life-table populations of the patients with mental disease, 25 per cent dying in from four to six years, 50 per cent in from thirteen to seventeen years, and 75 per cent in from twenty-eight to twenty-nine years. In the general population, the corresponding periods would be about thirty-two, forty-eight, and fifty-six years, respectively. Such heavy mortality results in a reduction of approximately eighteen years and fourteen years in the life spans of the male and female patients, respectively.

3. There are significant differences in the direction of the trends of the mortality rates in the early years, rates among patients decreasing, whereas those in the general population increase steadily.

4. The male patients have an expectation of life of 19.17 years at twenty years of age, as compared with 18.06 years among females. At twenty-two years of age, the expectations are 19.02 and 18.18 years for males and females respectively. In the general population, in 1920, the corresponding expectations at age twenty-two were 41.40 and 42.98 years.

ABSTRACTS

UNHAPPINESS AND MENTAL DISEASE. By Donald Gregg, M.D. *The New England Journal of Medicine*, 206:725–27, April 7, 1932.

Dr. Gregg presents here the conclusions reached as the result of a study of euphoria and depression among mental cases, the groups studied including the patients in a small private hospital, in a larger semi-public hospital, in a state hospital, and in a state school for the feebleminded.

In the private hospital, a census was taken month by month for eighteen consecutive months, the cases being checked plus, minus, or zero. Plus represented the happy or euphoric cases; minus the unhappy or depressed cases; and zero the individuals who were neither happy nor unhappy, seemingly uncaring or oblivious. "Thus at the end of each month an attempt was made to gauge the prevalent emotional tone in the hospital. In so doing a given case might, during the eighteen months, be listed at one period as minus, later as zero, and finally as plus. These lists were checked independently by three observers—the superintendent, the resident physician, and the head nurse, who were personally familiar with every case."

In the semi-public hospital, the census was taken for three consecutive months, the cases being checked independently by three physicians. In the state hospital, a single census was taken, the male cases being checked by one physician, the female by another. A single census was taken in the state school also, the data being supplied by different physicians from the different wards. The same definitions of the symbols were used by all the observers, however.

The total number of observations was 7,423—1,848 for the private hospital, 1,854 for the semi-public hospital, 2,030 for the state hospital, and 1,691 for the state school.

The percentages of the three classes of patients in each of the four institutions were as follow:

	Private hospital	*Semi-public hospital*	*State hospital*	*State school for the feebleminded*
+ cases	25	43	48	82
— cases	42	31	24	11
0 cases	33	26	28	7

The percentage of dementia-praecox cases was smaller in the private hospital than in the other two hospitals—21 per cent as opposed to 36 per cent in the semi-public and 50 per cent in the state hospital.

Commenting on these data, Dr. Gregg points out that the small private hospital is not equipped to handle adequately euphoric active cases of paresis or alcoholism. "Many relatively brief cases of depression are received. For economic reasons many chronic cases tend to move on to the semi-public or state hospitals. Consequently the percentage of chronic schizophrenic cases is smaller.

"The social status of most of the cases in the private hospital is such that the contrast between their hospital quarters and their homes is unfavorable, whereas in the state hospitals many of the cases find their hospital status more secure and comfortable than the environment in the community from which they came.

"These factors explain to a certain extent the varying figures in the four types of hospitals. The dominant factor, however, is the average social level. In general the social level and the intelligence level—meaning intelligence in a broad rather than a scholastic sense—run along together.

"These figures seem to indicate that the lower the residual intelligence level, the lower is the percentage of unhappiness and the higher the percentage of happiness; and that the higher the intelligence level, the higher is the percentage of unhappiness and the lower the percentage of happiness.

"In none of these types of hospitals, however, do the figures show a majority of unhappy cases. The majority are either happy or oblivious. Lay opinion is based largely on the reports of recovered depressed cases, and the opinion of a recovered patient regarding the environment occupied during his depression is open to question. Visitors to mental hospitals are naturally more forcibly impressed by the appearance and behavior of depressed cases."

Since suicide may be considered evidence of the most profound unhappiness, a further study was made of the diagnoses in the cases of suicide at Massachusetts state hospitals during a fifteen-year period (1913–1928). There were 192 of such cases. A classification of them according to prognosis gave the following results:

Favorable prognosis		*Unfavorable prognosis*	
Manic-depressive	76	Dementia praecox	41
Undiagnosed	10	Undiagnosed	16
Alcoholic	14	General paresis	7
Situational psychosis	1	Epilepsy	4
Involutional melancholia	3	Imbecile	7
Neurasthenia	3	Psychosis with arteriosclerosis	3
		Paranoid condition	2
		Senile psychosis	2
		Constitutional psychopathic inferiority	3
	107		85

"Here," Dr. Gregg comments, "the diagnosis of manic-depressive insanity predominates. If to the manic-depressive cases are added the alcoholics, the neurasthenics, a proportionate number of the undiagnosed cases, and some of the other cases of favorable prognosis, a majority of the cases can properly be grouped as recoverable cases. Suicide in mental disease is commonly an acute and early symptom rather than a late symptom in a chronic case. Were the data of the mental diagnoses of all suicides available, I believe the predominance of recoverable conditions would be much more marked than these figures indicate.

"The highest recovery rate at the Massachusetts State hospitals is found among the alcoholics and the manic-depressive cases. Among these two groups, also, are found the most commonly frank disturbance of emotional tone in the direction either of elation or depression.

"From this study of emotional tone based on over seven thousand observations, and from a study of the last report of the Massachusetts Commissioner of Mental Disease, I believe that the following conclusions can be drawn:

"*First:* The majority of cases in mental hospitals—even in hospitals receiving a large number of acutely depressed individuals—are not unhappy.

"*Secondly:* Unhappiness in a hospital group varies directly with the general residual intelligence level.

"*Thirdly:* The more the intelligence is impaired, the less unhappy is the patient likely to be, but the poorer is the prognosis in most cases.

"*Fourthly:* The layman's estimate of the unhappiness in mental hospitals rests on biased sources of information.

"*Fifthly:* Suicide in the majority of mental cases occurs among recoverable rather than non-recoverable cases.

"*Sixthly:* In the majority of cases unhappiness is a symptom of favorable prognostic value."

PRIMARY AND SECONDARY STAMMERING. By C. S. Bluemel, M.D. *The Quarterly Journal of Speech*, 18:187–200, April, 1932.

This author draws a sharp distinction between the initial stage of stammering as seen in the young child and the final stage as observed in the adult. The two stages are as far apart as the acute and chronic stages of infantile paralysis. The acute stage of infantile paralysis is characterized by inflammation of the spinal cord; the chronic stage is marked by muscular paralysis and other conditions which are sequelæ of the primary stage. Secondary stammering likewise consists largely of sequelæ.

With stammering, the primary disorder is a simple disturbance

of speech in which a delay ensues between the commencement and the completion of a word. In secondary stammering, the child has become conscious of his defect, and attempts to control it and conceal it. There is now physical effort in speech, with various respiratory disturbances, the use of starters and wedges, the employment of synonyms and circumlocutions, the appearance of confusion in the thought processes, and the association of emotional disturbances with speech and with the various situations in which stammering is anticipated.

In primary stammering the disturbance is most frequently seen at the beginning of the sentence, and it commonly assumes the form of repetition of the first word of the sentence. The child says, for instance, "I-I-I want that. Can-can-can I have it?" Often we hear repetition of initial consonants or initial syllables of words, and especially of the introductory words to sentences. The child says, "L-l-l-look at this. M-m-m-mother, what is it?"

It is characteristic of this primary or basic stammering that it may disappear and return, often repeatedly, over a period of several months or years. But eventually the secondary stage of stammering is reached.

The stammerer has now become conscious of his defect, and tries to force the articulation of his words. He squeezes the lips together or presses the tongue into the roof of the mouth in order to accomplish by physical exertion what he cannot achieve by natural fluency. In many instances he is unable to confine his muscular effort to the speech organs, and he jerks his head, wrings his hands, or even stamps his feet. These struggles have nothing to do with primary stammering; they represent merely his futile endeavor to contend with a disability that is beyond his understanding and control.

The same may be said of respiratory disturbances. The stammerer tries to talk after exhausting his breath, or he attempts to speak while inhaling instead of exhaling, he gasps in the middle of sentences, and in various other ways disturbs the normal rhythm of respiration. Then, too, there are respiratory disturbances due to emotion. These often precede speech, making their appearance as soon as the stammerer knows that he will be required to talk. Usually they become intensified with the act of speech.

Far removed from basic stammering is the use of starters and wedges. The stammerer intersperses his speech with such words as, "Well," and "Say," and "Listen." One little girl begins her conversation with "Oh, Oh, Oh."

An evasion of stammering is seen in the use of synonyms and circumlocutions. The speaker says "Empire State" instead of "New York State" because he finds the latter phrase more difficult. In

this same manner he may avoid difficult words and difficult situations a hundred times a day. These evasions have nothing to do with primary stammering; they represent merely the stammerer's attempt to escape from an impediment that is already established.

The search for synonyms often leads to confusion of thought. This is especially likely to be the case when the stammerer is confronted with a direct question, for the situation gives him but a moment to formulate a reply. Confusion also arises from indecision; the stammerer is fearful of words for which no synonyms are available, and he delays the act of speech because he knows that stammering is inevitable. Meanwhile he may stare helplessly at a mental picture of the printed word he wishes to say, or he may visualize the object he wants to name. While this indecision continues, he stands mentally transfixed. This confusion in the thinking processes may be of such severity as to make speech temporarily impossible.

The dominant symptom in secondary stammering is fear. This may be fear of letters, fear of words, fear of speech, fear of people, or fear of speech situations. A quarter of a century ago it was pretty well accepted that fear resulted from stammering, but the last twenty-five years have seen in psychology a remarkable emphasis on emotion, and many observers of stammering have again revived the fallacy that fear is the cause of stammering. A rather typical point of view is expressed by an English medical writer who says: "It is nearly always found that a deep-seated sense of fear is present as the underlying causal factor."

This point of view, however, is in no way borne out by careful observation. We see young university debaters pale and gasping with fear, and although they may show hurried speech and confusion, they do not display the impediment of speech that we know as stammering. It is evident, then, that fear as a mere emotion does not cause stammering.

Neither does the fear of speech cause stammering. The neurologist sees patients who are troubled with self-consciousness which becomes severe and disabling when they are required to talk. But when these patients are non-stammerers, their embarrassment does not produce stammering.

Finally, there is the theory that stammering results from the fear of stammering, the argument being that the impediment arises from auto-suggestion. Actually, however, one does not find fear of stammering in people who are not already stammerers. Then, too, it is seen that young children often stammer without self-consciousness toward speech. When their stammering is intensified by emotion, it is usually because of pleasurable excitement.

When fear affects the young child—and it does sometimes develop

quite early in stammering—one finds that the child usually becomes negativistic toward speech. He points, or says, "I can't say it," or he refuses to talk, but he does not display the emotional breakdown in speech which is so evident in the adult.

Having all these points in mind, one must conclude that the primary cause of stammering is not to be found in fear—whether it be fear as an emotion, or fear of speech, or fear of stammering. Fear is a result of stammering, and when it adds to the stammerer's difficulties, it does so as a secondary factor.

When stammering begins in early childhood, there is often a lapse of several years between the onset of primary stammering and the development of secondary stammering. Meanwhile, in many instances, the stammering comes and goes. But if the young child is scolded or punished for his impediment, or is made conscious of his stammering as a social defect, he may develop secondary symptoms quite early, in fact within two or three weeks of the onset of the primary speech disturbance. None the less one may recognize the transition from the primary to the secondary stage.

The author believes that primary or basic stammering is a form of mental blocking in which the mental speech is momentarily lost from the stream of consciousness. Speech is discussed as a conditioned reflex and the blocking or momentary amnesia is likened to the process of retardation or internal inhibition that Pavlow describes in his physiological experiments.

PSYCHOLOGICAL ASPECTS OF PHYSICAL EDUCATION. By A. S. Edwards. *The Journal of Health and Physical Education*, 3:15, 59–60, May, 1932.

In this short discussion of the part that physical education may play in the psychological development of the individual, the author stresses the point that physical training requires the actual application and continual use of health principles, as distinguished from the mere acquisition of knowledge about health. "Health *facts* are important; but health *habits* are hardly to be overestimated as part of an education. . . . We need not involve ourselves in the much debated question of formal discipline or of transfer of training. Experimental evidence is at hand to convince any one who will inform himself that there is, or may be, something general in training. We need not raise the question as to whether or not there are generalized habits. We may use the terms general attitudes and dispositions. Development of ideals, improvement in generalizations, or acquisitions of methods may insure that the training shall be effective in more than the particular situation in which the training took place. In precisely this very thing we find that physical education has

excellent opportunity. The development of the attitude of fair play, of ability to do hard work, to face the strenuous and perhaps the painful—these are things that are central to the very character of the individual. One who learns to have a reasonable self-confidence, to maintain self-control, and to hold without flinching to strenuous physical activity, is a different individual from one who is forever uncertain of himself, who shrinks from the painful, who avoids the unpleasant. Indeed the very requirements of the physical activities may afford opportunity for the detection of cases which need careful diagnosis on account of abnormal tendencies.

"Thus there may be revealed special opportunity for preventive work with children especially at the time when it is most valuable. The treatment of abnormal tendencies is most needed at the earliest possible moment. Lifelong suffering may be averted and even insanity avoided if cases are discovered at the beginning and not permitted to develop. The work of mental hygiene is closely bound up with general hygiene and is probably more than half of all hygiene. Just as psychology is needed in the development of a proper program of training, so some knowledge of the psychology of the abnormal makes its contribution to the work of teachers of physical education in their part of the work of prevention.

"Prevention of the development of abnormalities within is to be matched with the prevention of accidents and injuries from without. Safety education is largely a psychological matter. The safety of the mechanical side of automobiles at the present day is said to be well up toward 100 per cent. The safety of the human side of the automobile in flight is a dubious quantity. The automobile under human lack of controls kills more than did the Great War; it is said to be the cause of more deaths than is tuberculosis; and we are told that automobile accidents increased 1,050 per cent from 1911 to 1927. My point is that that part of the physical-education program which is concerned with public safety has essentially a psychological problem with which to deal. Public safety will not be secured until the problems of human behavior in relation to safety find their solution.

"One of the most valuable contributions of physical education may well be found in the development of scientific attitudes toward sickness, causes of disease, and effective treatment. Superstition and ignorance are to be overcome. Perhaps in no way better than in the demonstration of the results of the methods of physical education are the prejudices of ignorance and of superstition to be routed. In its dependence upon the sciences for its foundations it has the source, and in its methods, the means, of accomplishing much in this direction.

"Finally, it is most worthy of emphasis that in the social situations in which physical education is carried on, it has the prime condition for the development of moral traits. More than in the artificial situations of the schoolroom, it directs activity which goes on in the more real and vital situations of ordinary social living. In the give and take between individuals, in the need for coöperation and teamwork, in the struggle that requires strength, endurance, the consideration of fair play, physical and mental control, and accuracy of performance, moral traits are more essentially and vitally called into play; and here is the place for the most effective development of ideals which are to a very large extent at the heart of education. Here we may find thought, judgment, precise action, competitive effort of a high type, and the integrative activity that is just now finding its proper recognition."

BOOK REVIEWS

NIGHTMARE, WITCHES, AND DEVILS. By Ernest Jones, M.D. New York: W. W. Norton and Company, 1931. 374 p.

In his preface the author states that most of this book was written in the year 1909–1910, and that the greater part of it has already been published. The first section, on the pathology of the nightmare, appeared in the *American Journal of Psychiatry* in 1910. Much of the remainder is a translation from a monograph on the subject in German which came out two years later.

Answering his own question—why, in a study that has advanced as rapidly as psychoanalysis, it has seemed worth while to republish work done more than twenty years ago—Jones comments (p. 8):

> "For the true significance of the nightmare to be properly appreciated, first by the learned professions and then by the general public, would in my opinion entail consequences, both scientific and social, to which the term momentous might well be applied. What is at issue is nothing less than the very meaning of religion itself. In this book I have brought forward reasons why an intensive study of the nightmare and the beliefs held about it makes it hard to avoid the conclusion that religion is in its essence one of the means—hitherto perhaps the most valuable—of helping mankind to cope with the burden of guilt and fear every one inherits in his unconscious from the deepest stirrings of mental life, the primordial conflict over incest."

However, without the above explanation—and even if the ultimate significance of the subject is not so profound as the author believes—there is no need for hesitation or apology in presenting this volume. Quite apart from the psychoanalytic interpretations that run through the material and contribute its most absorbing interest, there is set forth a historical, critical, and clinical review of the whole subject so scholarly and comprehensive as to be its own justification. Such treatment gives values that are timeless and that cannot be made obsolete by changing psychological theories.

The book is divided into four sections. In Part I, *The Psychology of the Nightmare*, Jones points out that no other malady that causes human suffering is viewed by the medical world with such complacent indifference. He dismisses the more popular medical concepts which place the basis for the affliction in disorders of the digestion or other body functions, and maintains that it is chiefly a purely mental phenomenon. He feels that it is a sad commentary on the science of the nineteenth century that in the field of dreams,

old superstitions came closer to true explanation than the more rational attempts of the so-called scientific age.

In fairness, however, he points out that material science did destroy the old concepts of terror dreams by proving the endogenous origin of the phenomena, but in denying their fundamental importance and sexual nature, it went too far. So to speak, it threw out the baby with the bath. It remained for psychoanalysis to give once more the old importance to dreams and superstitions, but at the same time to fix their origin in the nature of man himself instead of permitting them to be projected into an imaginary outside world.

Typical nightmare has three cardinal symptoms: (1) agonizing dread; (2) sense of oppression and weight in the chest, which alarmingly interferes with respiration; and (3) conviction of helpless paralysis. Varying and various accessory features supplement this central syndrome. The typical nightmare shades off in all directions toward less intense anxiety dreams which have much that is common in origin. At times sexual orgasm occurs during the nightmare. This fact, and other convincing evidence, shows that there is connection between fear dreams and pleasurable erotic dreams, as if they were opposite sides of similiar phenomena, the night terrors standing as the negative of the frankly sexual dreams.

The main thesis of this first section is based on historical evidence from the literature, plus psychoanalytic findings in the study of special cases, and is set forth as follows (p. 44):

> "*The malady known as nightmare is always an expression of intense mental conflict centering about some form of 'repressed' sexual desire.* This conclusion, however, is probably true of all fear dreams, and we can carry it a step further in the particular nightmare variety. In this, dread reaches the maximum intensity known, in either waking or sleeping state, so that we should not be surprised if the source of it lies in the region of maximum 'repression'—*i.e.*, of maximum conflict. There is no doubt that this concerns the incest trends of the sexual life, so that we may extend the formula just given and say: *an attack of the nightmare is an expression of a mental conflict over an incestuous desire.*"

Part II deals with the connections between the nightmare and certain medieval superstitions. There is, first, a discussion of the relation of dreams to beliefs in general, summarized on page 65:

> "The conclusions reached up to the present are as follows: in the first place, dreams have played an important part in the genesis of beliefs in a soul that can live and move apart from the body, in fabulous and supernatural beings, in the continued existence of the soul after death—with its power of returning from the grave and visiting the living, especially by night—in the connection between this idea and the spirits of departed ancestors (leading to the worship of these), in the possibility of human beings being transformed into other persons or

into animals, in the identity of the spirits of animals with those of ancestors, and in night flights through the air. In the second place, the various conceptions just enumerated are closely associated with one another. The explanation of this strange connection between ideas apparently so remote from one another has always been impossible until Freud's discovery of psychoanalysis provided an adequate instrument for the investigation of deeper processes of the human mind."

The special connection of the nightmare in the production of certain false ideas is the main theme of this section. These ideas were organized into superstitions and became motivating influences which from earliest times have had profound sociological and psychological effects. The author gives a separate chapter to each of the most notable beliefs springing from this common origin, to wit—the incubus, the vampire, the werewolf, the devil, and witchcraft. He states (p. 57):

"For three hundred years, from about 1450 to 1750, they were fused together and reached their acme of importance; they are still accepted by many in their original form, and by far more in their essential elements. The deepest source of them is identical with all, and they have been responsible for an incalculable amount of human suffering. These sources are still active in human nature, even though the expression of them has changed in the last couple of centuries, so that interest in the subject is far from being a purely antiquarian one."

On page 347 findings and conclusions are summarized:

"It would seem worth while now to review the characteristic features common to the five groups of phenomena considered above. In the first place—and this is one of the main theses of the book—they all represent constructions built out of numerous elements which not only had an independent existence previously among the beliefs of European peoples, but which are still to be found to-day in widely separated parts of the world. For the fusing of the constituents into a composite belief the Christian Church bears in every case the prime responsibility, in four cases the Roman Catholic and in one the Orthodox Greek Church. It is worthy of note that leading authorities of the Church had repeatedly, previous to the twelfth century, denied the truth of the popular beliefs in these constituents, particularly sorcery, lewd intercourse with Incubi, transformation of human beings into animals, night journeys with demons and witchcraft, and had insisted on the dream origin of these beliefs; it was reserved for the Middle Ages to plunge into an obscurantism that the so-called Dark Ages had rejected. The composite beliefs in question endured approximately three hundred years; after their course was run they did not vanish, but dissolved once more into their original elements."

Part III is entitled *The Mare and the Mara; a Psychoanalytical Contribution to Etymology.*

This section discusses the place taken by the horse in infantile sexuality, in superstition, and in general symbolism. One hundred

pages are packed with an exhaustive and erudite exposition of the subject, perusal of which will warm the heart of the academic, even if the average reader gets a headache. This section cannot be discussed in detail in this review. Let it suffice for most of us to learn that the mare in nightmare is not merely a verbal accident, but in all truth a horse! This horse, loaded down with a complex symbolism inspired by its strength, its speed, and its shining splendor, gallops through the night and, set loose in the mind of conflict-ridden mankind, brings the moisture of anguish to the brow. (Let neurotics give thanks that it is not elephants instead of horses that pursue them through the darkness.)

Part IV consists of a short and concise "Conclusion." Two quotations will bring out important practical points of view from the religious and neurotic angles, respectively:

> "The analysis of the belief in the Devil, which may nowadays be classed as a superstition almost as definitely as the four other superstitious beliefs here treated, reveals it to be a derivative of the infantile conflicts over sexual and hostile wishes concerning the parents. This must raise the question whether the other aspect of the same Being, the divine aspect, does not represent merely another line of development from the same source." (p. 346.)

> "A close analogy can be shown to exist between the phenomena here investigated and psychoneurotic symptoms; they are, indeed, to a large extent identical. Both originate in the repressed sexual wishes of early childhood, which remain scarcely visible until external conditions compel certain sharply defined manifestations of them. The gradual disappearance of the superstitions took place in the same way as a spontaneous recovery does with neurotic symptoms, partly from an increase of the repression, partly from a fresh outlet being provided for the underlying trends. . . . The possibility of a relapse into the old superstitions has to be rejected on many historical grounds and would indeed be hard to imagine in our modern civilization, so that another group of outlets has to be found. There is much reason to think that the chief one of these has been the increase in individual psychoneurosis. In making the nice comparison between the amount of neurosis in modern and in ancient times respectively, we may venture to guess that the main difference has been not in the actual quantity so much as in the different distribution of the manifestations." (p. 348.)

The book reveals Jones at his best. It shows his profound scholarship and clarity of thought, his masterly logic and simplicity of style. Unsympathetic critics may maintain that along with these qualities there are others less praiseworthy, in the way of unwarranted dogmatism and too great simplification of material.

The reader may also on good grounds fail to follow Jones through to some of his conclusions. For example, granting that the forms of religion have been illusions, no less so were the first substitutions

by material science. It is probable that the theoretical contributions of psychoanalysis are still other illusions, more suitable to a present-day ideology than their forebears, but by no means marking the replacement of total error by total truth, as the author seems to imply.

The book is heavily documented on every page and there is free quotation from many authors. All the German is thoughtfully translated in brackets, while the reader is left to his own French. The authors' index alone covers six pages.

On an opening page, the subject of the book is happily introduced in poetry by a quotation from Erasmus Darwin, while as frontispiece a good reproduction of a painting by J. H. Fuseli (1782) gives the artist's conception of nightmare, thereby bringing art to the pleasant and efficient service of science. The publishers have given the volume a lurid red-and-black cover which sets the proper atmosphere and even at some distance gives delightfully ominous promise of the devils' dance and witches' brew to be found within.

Psychoanalytic literature is notably enriched by the presentation of this work in one English volume, and many other fields of knowledge will be no less indebted to the distinguished author.

MARTIN W. PECK.

Boston.

MEDICAL PSYCHOLOGY; THE MENTAL FACTOR IN DISEASE. By William A. White, M.D. New York and Washington: Nervous and Mental Disease Publishing Company, 1931. 141 p.

For a long time it has been realized that a volume on medical psychology for the present-day medical student has been needed. There are also many physicians—and we believe the number is growing—who have been out of medical school and in the practice of medicine for some years and who are realizing that many of the ills that they are called upon to treat have direct psychological implications and that their previous training has been inadequate for a proper understanding and evaluation of such psychic reverberations. An up-to-date work as a textbook or reference book for these two groups is, therefore, a most important contribution.

The volume we are reviewing was written by a scientist who, over a long period of clinical experience and of teaching, has ever continued to be a profound student and who is, therefore, most admirably qualified for this important work.

Dr. White presents a medical psychology that has been brought strictly up to date. Unless the medical student or the practical physician has had a fairly good grounding in psychology, he will find this volume serious reading—will have to reread many paragraphs

and from time to time consult a dictionary of psychological terms. Perhaps the author did not wish to make the volume too simple, so that readers would get the impression that so complicated a matter as mental motivation can be understood without much mental effort. However, for the student who wishes a thorough grounding in the functions of the mind and who is willing to make an earnest intellectual effort to obtain this, the book will prove most stimulating, thought provoking, and illuminating.

Medical psychology, as expounded by Dr. White, is based on the significant present-day conception of psychology as a biological science, and all the way through the book the concept of "the organism-as-a-whole" is emphasized as absolutely essential to the understanding of man and his mental and physical reactions. This makes the work most refreshing, in contrast to the older academic, philosophic presentations. In fact, one whole chapter is devoted to the organism-as-a-whole, dealing with integration, structuralization, individuation, and genesis. To some of us, such a term as individuation may at first seem baffling, but when we realize, as White states, that it is the tendency to more specific differentiation that the term individuation applies—a process the increased specificity of which in the higher organisms, such as man, differentiates each member of the species as distinct, because different, from every other member—we realize that it is an adequate term for a very important principle in the growth and development of protoplasm.

This instance is cited to show that one should not hope, by skimming through the book, to get an adequate understanding of the psychobiological foundations that are necessary for a thorough grounding in the problems involved in the growth, development, and deviations of man.

A number of chapters are devoted to the psychoanalytic approach to mental mechanisms. These chapters do not seem to the reviewer quite as complex as some of the preceding chapters. In them Dr. White has given us a relatively condensed and simple exposition of that vast new field with which he is so thoroughly acquainted.

All through this volume we are presented with the latest and most scientific data to prove the points of view presented. Each chapter has a most concise and helpful summary. For years to come Dr. White's *Medical Psychology* should serve as a brief scientific treatise of the subject dealt with.

Not to underestimate the main body of this scientific treatise, but rather to bring it to the attention of many others besides the two main groups of readers indicated in the first paragraph of this review, I wish to state that the last chapter, the Conclusion, is a delightful summary, a valuable essay, and an important literary contribution

to all those who have any interest in their fellow men and who desire to grow in understanding of man's development, his struggles, his adjustments, and his maladjustments.

ARTHUR H. RUGGLES.

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ORDER OF BIRTH, PARENT-AGE, AND INTELLIGENCE. By L. L. Thurstone and Richard L. Jenkins. Chicago: The University of Chicago Press, 1931. 135 p.

This book, with its clumsy title, is divided into two parts—a survey of the literature on the influence upon a child's mental, physical, and emotional development of such static factors as order of birth of the child, age of parents, and number of siblings; and the statisticians' own computations, chiefly on the order of a child's birth and its relationship to that child's intelligence.

The survey of the literature is exhaustive and well and briefly abstracted. There is a marked absence, however, of the penetrating type of criticism with which Jones surveyed this same field in his *Order of Birth in Relation to the Child* in the recently issued *Handbook of Child Psychology*. And after all, one of the chief virtues of a survey of this kind is the final evaluation by the historian of each contribution. If the reader is interested in critical aspects of previous work in this field, let him turn to the *Handbook*. For a more inclusive set of brief summaries of related studies, he will like Jenkins' review.

In connection with their original investigation, the workers tabulated about fifteen hundred children (seven or eight hundred families) who had been referred to the Institute for Child Guidance in Chicago because of mental or behavior deviation and upon whom intelligence tests had been done. They then correlated the intelligence of these children with order of birth, number of siblings, age of parents, number of miscarriages in the family, and interval between successive births in the families. The most important parts of the study deal with the relationship between a child's intelligence and such influences as ordinal position, size of family, age of parents, and time interval between successive births. Most of the other problems are represented by a much smaller number of cases. In fact, in some instances the subgroups under the main problems become pretty attenuated, too.

The writers feel they are justified in drawing the following conclusions from their tabulations:

The intelligence of children increases progressively with each successive advance in ordinal position within the family. The second-

born child is more intelligent than the first-born, the third-born is more intelligent than the second-born, and so on.

There appears to be a definite relationship between size of family and children's intelligence. Smaller families are made up of more intelligent children. These same smaller families, however, also have relatively more mental defectives within their ranks than larger families. In other words, the smaller families include more children from the two extremes of the intellectual scale.

There seems to be little relationship between the ages of the parents at the time of the birth of a child and the intelligence of that child. In so far as the number of cases is at all adequate, a maternal sterile interval of up to three years is not prejudicial to the intelligence of the oncoming child.

Before discussing the significance of these findings, we would do well to see how indubitably they are established. In connection with the conclusion that younger children (later born) are more intelligent than older siblings in the same family, it would be well to keep in mind that this finding is based upon a sampling of a problem population. Does this factor unduly weight diminishing intelligence with advancing years? A large number of mental defectives are included in this problem population. Is it not safe to assume that older siblings are more likely to be brought to the clinic for intellectual deviation, whereas younger siblings would call attention to their need of clinical study by conduct disorders? (Intellectual impairment, unless it be extreme, is more likely to bring itself to the notice of the clinic as the child gets older and unsuccessfully faces school competition or vocational demands.) In this way many younger siblings with impaired intelligence, but passable conduct, would miss clinical investigation and tabulation. There is some evidence for this point of view. The writers' own study on the relationship between age and intelligence shows a drop in intelligence for years five and six, years twelve and thirteen, and all the years over eighteen. (In the last group the number of cases is insufficient.) These years might have something to do with age of entering school, age of graduation, and period of vocational stress. Whatever the causes of the variations at these age periods, they suggest the possibility of selective factors that may operate to throw out of alignment the natural relationship between the intelligence of younger and older siblings.

Further evidence for the possibility that a problem population may introduce special conditions is brought out by the study of Dr. Minnie Steckel, *Intelligence and Birth Order in Family*. Working on a much larger number of non-problem public-school children, this experimenter found that the intellectual differences between siblings

that appeared in Thurstone's and Jenkins' cases was diminished by almost half when, presumably, the special selective factors that creep into a problem population were ruled out.

But assuming that there is a difference in I.Q. in favor of the later-born child over the earlier-born, is this difference a real difference in intelligence? The psychologists themselves tell us that the scale inequalities of the Binet-Simon measuring rod do a progressive injustice to older children. Older children—the first-born, as it were—are penalized by being measured intellectually by a rod that has thirty-seven inches to the yard. If this difference is equal and progressive, it might easily account for the fact that first-born children (the older ones) seem to be one inch intellectually shorter than their second-born siblings.

Aside from this question of scale inequalities, there is also the question of the limited number of tests at the upper range of the Binet scale, a penalty older children are, of course, more likely to run up against. An older child may really be a little brighter than his test shows because in his case the measuring rod only goes as far as thirty-six inches, whereas, if the rod were long enough, he would measure thirty-seven or -eight inches. Therefore, in spite of the thoroughness with which Jenkins did his work, one must hesitate before accepting his conclusions with regard to the relationship between ordinal position and intelligence because of the possibility that selective factors may have crept into his bag of beans, and because of the possibility that inequalities in the intelligence tests may penalize older children and make it necessary to "control for age." One need not go into the question, Can intelligence be measured with caliper-like precision?

It has always been known (see Terman *et al.*) that, in general, children in larger families are less intelligent than children in smaller families. Large families are more common among the poorer economic groups of the community, and since there is a strong positive correlation between economic status and intelligence, there is perforce a high positive correlation between size of family and intelligence. Less well known is Thurstone's finding that the smaller families also harbor a larger percentage of mentally defective children. Is this really so? And if so, what is the possible explanation of it? On about three hundred cases of children whose I.Q.'s run between 0 and 49, the correlation between size of family (sibship) and intelligence is $+.04 \pm .04$—surely no valid statistical difference here for this type of material. When the line is drawn at I.Q. 65, the correlation is a little higher: $+.15 \pm .02$. Again one feels the coefficient does not warrant a letter to the London *Times*. Accepting this finding as

significant, the writers feel encouraged over the fact "that there is a point beyond which defective intelligence is unfavorable to biological survival." Would it not be more correct to assume—if this finding means anything at all—that syphilis interferes with fecundity and is more likely to go untreated in lower-grade families? A table giving the relationship between the economic status and the intellectual status of each subgroup would have been very revealing at this point.

The other findings in this study, being to all intents and purposes neutral, call for little comment. Unfortunately we cannot comment on a very much worth-while study of the relationship between incidence of problem children and sex of nearest sibling since the writers' conclusions seem to be so much at variance with their own statistical evidence that the reviewer must assume, in explaining these discrepancies, that many typographical errors have crept into this chapter—or that attempting to follow so many figures makes a reader a little confused.

So much for the findings of this monograph. What is their value to practitioners in the field of child guidance? What is the value of this type of research in general? Assuming that the researchers' measuring rod (the Binet-Simon tests) has been handed down by Moses himself and that there is a slight difference in intelligence between any two ordinal positions in the family constellation, what of it? Surely this fact would not be so weighty in explaining the social adjustment or maladjustment of two children in those relative positions as "the eyebrows their mother raises" in approval or disapproval of their behavior.

Clinicians should have some feeling for statistical method. But statisticians should have some feeling for the clinic. To be sure, no claim is made in the monograph for the practical value of this type of research except by implication in its foreword: "It [the study] may be taken as a model of the kind of careful research and cautious presentation of findings that will slowly, but surely add successive increments to our knowledge of human behavior." I wish I could agree with this statement. Have these workers done more than attempt to check up on problems on which clinical "hunchists" have been making no very serious misstatements? And are there not a good many problems in the borderlands of psychology and psychiatry (and perhaps sociology) where a statistical check would help to clear away a good deal of prejudice? Think of the valuable possibilities of statistical checks upon Freudian concepts. And does not the value of any statistical study lie not only in establishing certain facts, but in calling attention to the hypotheses that underlie those facts? Statistics are surely the beginning of a scientific approach and not

the end of it. In spite of, or perhaps because of, "careful research," there is not a good guess in a bookful of this work. I suppose scientific style has to be dull, too, but surely it would permit a few more graphic representations.

But in spite of all these criticisms, I am glad to have this book.

JOHN LEVY.

Columbia University.

PSYCHOLOGY OF INFANCY AND EARLY CHILDHOOD. By Ada Hart Arlitt. New York: McGraw-Hill Book Company, 1930. 382 p.

In reading this clear and excellently written book on the psychology of the pre-school child, one feels considerable regret that a writer who is able to express herself so intelligibly should apparently be limited by the behavioristic point of view. The book's possibilities for usefulness are decidedly curtailed by the fact that there is so little recognition and exposition of the unconscious motivations of human behavior and their fundamental significance in the parent-child relationship, as well as in all relationship situations. The psychoanalytic point of view is conspicuously absent, though some of the terminology is used. Consequently, while the author has written from actual first-hand experience with little children, the approach is so mechanistic that we are apt to get an impression of the child as a laboratory specimen—definitely controllable, in a controllable situation—and not as a subtly interacting unit of a dynamic social organization—the family. Perhaps the most striking thing about human behavior and adjustment is the surprising disproportion between cause and effect. This text leaves one with the comfortable, but unsound impression that intelligent and planful manipulation of external "causes" will eventually lead to desired effects. The simplicity is disarming, but to the experienced teacher or parent, fallacious. It just doesn't work out like that, and why it doesn't would seem to merit at least half the pages of any adequate book on child psychology.

Beginning with a brief chapter on the general significance of the pre-school period, the author follows an orderly and natural presentation of individual development. In succeeding chapters the reacting mechanisms, the innate make-up of the child at birth, the stimuli to response and types of response, education and socialization through control of experience, the gradual building up of mental activity on a basis of sensory experience and association, forms of expression, and individual differences, are all concisely handled. In general, the material is well presented throughout, and very readable, and the frequent use of illustrative, practical cases tends to clarify the statements.

Chapter II, on heredity, is largely devoted to an account of statisical studies in heredity. The momentous implications of the division of the chromosomes in the germ cell, with the resulting unpredictable redistribution of paternal and maternal hereditary elements, are given one paragraph, which is neither clear nor complete. One is also told that "hereditary traits" are carried by the chromosomes, a misleading concept that has been vigorously rejected by modern biologists. In this chapter one feels that the use of illustrations and a full and detailed account of the biological foundation of the individual would have added immeasurably to the value of this book.

Chapter III is an exposition of the innate reacting mechanism. The description of the sensory organs, the coördinating and controlling mechanisms, the organs of response, is unusually clear and simple, though at times somewhat technical for the average parent. Such phrases as "mediate primary sensations of color," the frequent use of the term "conditioned" in Chapters II and III without any previous explanation of this term, and unexplained references to the work of Pavlow, indicate the difficulties that must be met by the uninformed in reading this text. The recent findings of Lashley in regard to the non-specificity of localization in cortical areas for learning are reported—a valuable addition.

Chapetr IV continues the discussion of innate response—the physiological reflexes and random movements from which are developed the later varied range of muscular coördinations. The author's attitude toward the problem of "handedness' is apparently based upon the experiments of Watson, and is indicated by the following: "It seems reasonable to suppose that a child may *with perfect safety* be conditioned in infancy to use the right hand." In view of the highly controversial nature of this topic and the results of more recent research, a less dogmatic conclusion seems desirable.

Chapter V enumerates the instinctive tendencies, of which the author recognizes six. Whether the "tendency to take care of weaker things" would not logically come under the tendency to self-assertion is an open question. The distinctive value of the author's contribution here is her translation of these reaction tendencies into practical terms of specific behavior and learning situations.

In her discussion of the sex tendency, one would seriously question such phrases as "bad sex habits," as well as her description of "the first period from infancy to between three and five years of age" as "a *neutral* period in which there appears to be very little interest in sex and in which the side of the sex instinct that is stimulated is largely psychic." One queries also such a dogmatic statement as the following: "The guidance of the sex life of the child . . . is a

difficult problem . . . unless the child has received *definite training in those qualities of character which underlie self-control.*" (The italics are ours.)

Chapter VI, VII, and VIII give very detailed descriptions of nervous-system control and of the physiological changes that occur in emotion. The primary emotions are discussed fully. The causes and reconditioning of *fear* are handled, with discussion of the various "flight mechanisms," all with case material illustrating the practical implications for adequate adjustment and methods of dealing with problems. Anger tendencies are handled in the same manner.

The discussion of the *love* tendency is very superficial. The psychoanalytic point of view is ignored and no recognition is given to the Freudian concepts of infantile sexuality or the Œdipus situation. No attempt is made to discuss or to analyze the emotional difficulties of the parents themselves as causative factors in the development of fixations at various stages of the child's emotional development. The author states that " the later possibilities of block in normal emotional development *occur so far beyond the pre-school period* as to warrant no discussion here." Such ignoring of the dynamics of the family relationship immeasurably weakens this otherwise excellent book.

Habit formation is covered in Chapter VIII, with an enumeration and explanation of accepted facts and information, illumined by a wealth of actual illustrative material in terms of everyday training methods and activities of children. Sensation and perception are well handled in the next two chapters, with special emphasis upon the necessity for providing the widest range of experience for the child in order to help him develop adequate concepts of his environment and build up correct relationship values in terms of distance, time, space, number, direction. The author emphasizes that varied experiences are the basis for adequate memory and recall, and limited experience and relationships render the child prone to errors of memory and discrimination. She stresses the value of experience with *concrete* objects for memory training and the necessity for making as rich an association as possible between new and old experience in order to facilitate recall. Again, in Chapter XI, she emphasizes the relation of actual experience to a rich associative concrete imagery in sensory fields as determining the child's later ability to enjoy verbal and symbolic imagery, as well as to be productively imaginative.

In explaining the thinking process (Chapter XII), she traces the development of the thinking process of young children from the "chain of vague ideas and *clear reactions*" to the gradual substitution of trial and error in terms of ideas for trial and error in terms of actions. She stresses the various factors—such as difficulty of recall

or experience; the handicap of inexperience with ideas involving time, size, weight, distance, direction, and number; meager vocabulary, and the like—that operate to make the thinking processes of children illogical and in need of constant interpretation and redirection.

Chapter XIII discusses language, drawing, and other forms of expression. The importance of a meaningful vocabulary for adjustment to everyday situations as well as of verbal symbols for carrying on thinking is outlined, with stress on the first four years as the important period of acquisition. The various periods of speech are described, with the practical difficulties that are common to each. Stuttering is very superficially handled, but it was probably the intention of the writer to omit any detailed discussion of so difficult a problem, though a brief summary of the most authoritative information on the subject would have added a great deal to this chapter. Much stress is laid upon the importance of a sympathetic and patient answering of children's countless questions. "The world in which the young child lives is much too complicated for him to find out what he wishes to know through his own exploration and experimentation. He can learn only if his questions are answered correctly and in as much detail as he can comprehend."

Concise discussions of drawing, rhythm, and music follow. These are very brief and merely descriptive; there is little in the way of practical help for the parent or teacher as to how best to encourage these expressive activities. The acceptance of the "*monotone*," with actual suggestions as to how he can be fitted into the group singing, is rather unfortunate. The consensus of opinion and experience seems to be that true monotones are rare, and that most so-called monotones can be tone trained with intelligent handling.

Social attitudes and the development of personality are handled in Chapter XIV. This chapter is most inadequate, as here again no consideration is given to the powerful dynamics inherent in the family situation and their results upon developing personality. The whole question of social development and attitudes is handled upon what seems a somewhat mechanistic, behavioristic basis.

Chapter XIV deals with individual differences, largely from the statistical point of view, and the relative contributions of nature and nurture.

Special problems are covered in the last chapter, which gives the essential rules of general habit formation and their practical applications in eating, sleeping, toilet, and play situations. These are very adequately handled except that the more profound emotional factors that enter into all conditioning and the fundamental dynamics of relationships are again not considered.

Fairly complete author and table indexes complete the book. Though the author states in the preface that the book is designed primarily for parents, it would seem better adapted for use as a textbook for students.

HARRIET MITCHELL.

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INSOMNIA: AN OUTLINE FOR THE PRACTITIONER. By H. Crichton-Miller, M.D. London: Edward Arnold and Company, 1930. 172 p.

We have here a thorough exposition of the subjects of sleep and sleeplessness. The opening paragraph of the first chapter defines and explains the situation admirably:

> "Sleep is the state of minimal normal activity of mind and body. It is an outcome of evolution. It is a phenomenon of dissociation and a manifestation of equilibrium, brought about by a mechanism as yet unknown, susceptible to both physical and mental influences, conditioned by security, and characterized by an altered relation of the ego to its environment."

After an elaborate discussion of the many statements of this definition of sleep, the chapter closes with a similarly explanatory definition of sleeplessness:

> "To sum up, then, we may say that insomnia consists in a failure to achieve to a normal degree and under normal circumstances that state of minimal activity of mind and body which we call sleep; that it consists in an interruption of the mechanism (as yet undiscovered) which regulates dissociation; that it is disturbance of the diurnal rhythm of anabole and katabole, which has been evolved from our earliest terrestrial ancestors; that it may be associated with mental or physical causes or with both; that it is a manifestation of disequilibrium or insecurity; and that it is characterized by a failure of the ego to attain detachment from his environment."

Chapter II deals with the treatment of insomnia, stressing environment, massage, general relaxation, circulatory conditions, digestion, occupation, and the patient's attitude toward the condition. The next chapter considers the physical aspects, including the vascular, the metabolic, and the neurological, and the matter of the conditioned reflex. The chapter on medicinal treatment is exhaustive, with excellent notes on the use of eighteen of the more commonly employed hypnotic drugs and emphasis on the fact that "the chief object of administering a hypnotic is to enable the patient to do without it."

Chapter V, which discusses the psychological aspect of insomnia, covers briefly, yet clearly, the field of psychoanalysis, under the headings: "Sleep as Dissociation," "Dreaming and Hypnosis," and

"Equanimity a Principal Condition of Sleep." We find here also attitudes toward the conflict of human life under such headings as: "The Traditional Religious View," "The Materialistic View," "The Biological View," "The Freudian View," and "Jung's View."

The relationship of the emotions and insomnia is dealt with in a chapter on psychotherapy, while in Chapter VII many case records are outlined and discussed in a most interesting and enlightening manner. Case 6 is unusually well done, bringing out the author's broad point of view and the latent possibilities of treatment if a careful study is made of the total reactions of the neurotic personality.

As suggested by the author in his preface, this volume will serve as an introduction to the wider problems of the psychoneuroses, and the therapeutic approach indicated should prove useful to the practitioner in the handling of all functional nervous disorders.

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COMMON ANNOYANCES—A PSYCHOLOGICAL STUDY OF EVERYDAY AVERSIONS AND IRRITATIONS. By Hulsey Cason. Princeton: Psychological Review Company, 1930. 218 p.

The annoyances with which this study deals do not include physical pains, nor rational annoyances such as losing money or breaking one's watch, but rather, to quote the author, "the learned, not easily predicted, and somewhat irrational annoyances . . . of everyday experience."

From material gathered from 659 persons ranging in age from ten to ninety years, a list was compiled that included 2,581 different annoyances. This material Professor Cason classified into five groups—annoyances that have to do with (1) human behavior; (2) non-human things and activities, exclusive of clothes; (3) clothes and manner of dress; (4) alterable physical characteristics of individuals; and (5) persisting physical characteristics of individuals. Annoyances associated with human behavior were the most common, 59 per cent of the 2,581 falling in this group. The other groups ran down the scale in the order mentioned from 18.8 per cent to 4.4 per cent. From this it would seem that we are annoyed chiefly by human behavior.

Of the 2,581 different annoyances, 507 were selected for further study, on the basis of frequency, age distribution, and concreteness. Some regard was paid also to universality, permanence, and the psychological and social significance of the annoyance. These 507 different annoyances were submitted to 625 persons, each of whom was asked to grade them into those not annoying to him personally,

those slightly annoying, those moderately annoying, and those extremely annoying. In addition to this, each subject gave data on himself covering age, height, weight, sex, marital condition, education, occupation, etc. No significant correlations were found with any of these factors, except that in general it would seem that women are more easily annoyed than men, though many men are more easily annoyed than many women. The author cites literary references which show that human beings, over the course of centuries, have not changed much as to what is annoying.

In addition to the foregoing descriptive study, Professor Cason undertakes an interpretative or explanatory analysis of his data. From the selected 507 annoyances, he chose 192 and submitted them, with appropriate instructions, to a total of 535 persons. "Each subject therefore selected a few of the annoyances about which he felt most certain and wrote his views on the origin of each annoyance, its psychological or social nature, why it was annoying to him or to others, what it was associated with or reminded him of, whether there were any conditioning or limiting factors, whether it called out disgust, or fear, etc., and what he usually did in the situation."

In this way 7,200 explanations were obtained. Professor Cason devotes some 77 pages to a consideration of the explanations of the 192 annoyances or groups of closely related annoyances, summarizing each in a paragraph or two. He states that his own views, "which are sometimes different, do not always appear in the text." While it is perhaps to be regretted that the author's views are in this way not distinguishable from those of his subjects, the summaries he gives have the apparent value of being an impersonal digest of the explanations given by subjects of average intelligence.

Preceding the chapter that contains these summaries, which is entitled *The Nature of Common Annoyances,* is a chapter devoted to "principles of explanation." There are nine of these. "We have arrived at these principles," Professor Cason explains, "after a detailed study of the psychological factors involved in the individual annoyances themselves, and the method of approach has been largely inductive."

The first principle is that of "unpleasant association." One is apt to be annoyed by stimuli that bring up unpleasant associations, however they were accumulated. Secondly, one is annoyed by that which acts as an "interference with pleasant activity"; and thirdly, by that which "opposes the ego tendency"—*i.e.*, that which by overt expression or act, or by innuendo of any sort, indicates or suggests an inferior or reduced rating of the individual in respect to dignity or some other valued respect. The fourth principle is that of "identi-

fication"—that is, one puts oneself in the place of another and so experiences the supposed feelings of the other, as, for instance, when that person is harshly or unkindly treated. As a fifth principle the author gives "regression"—*i.e.*, the tendency, manifest in most of us, to return to acts that at various stages in our development were pleasurable, however unwelcome a recognition of this now may be. Partly as a measure of defense against such recognition, we are prone to react unconsciously against the regressive tendency, and to find annoying that which calls out this reaction, as, for instance, some one eating soup noisily or picking his nose.

The sixth principle of explanation the author calls "undue familiarity." This is operative, for instance, when a relative stranger assumes a privilege that is unwarrantably intimate, as when a person one scarcely knows slaps one on the back or puts his hands on one unnecessarily. The author recognizes that this might well be subsumed under the principle of "opposing the ego tendency."

The seventh principle is concerned with what the author calls "discards from the body." This functions in such annoyances as being near a person who is vomiting, or seeing a person blowing his nose without a handkerchief, the odorous condition of another's body, etc. It is perhaps of minor importance whether many annoyances of this class might not better be explained by the principle of "regression."

The eighth principle is exemplified in a few fairly unimportant instances, such as "discords of music," "a person scratching his finger nail on the blackboard," or "very intense stimuli of any sort." These annoyances the author designates as operating under the principle of "inherited tendencies."

A final, ninth principle he calls "customs, conventions, and taboos." These are learned acts, a departure from which on the part of others or of ourselves may amount to an annoyance.

The author admits that the principles may overlap, and that it may be necessary to employ more than one in dealing with a simple instance. He is under no misapprehension as to the complexity of his undertaking. He regards the "principles" as worth while or useful if they contribute something to the understanding of the situation in question. One infers that he would be the first to admit the value of many criticisms that might easily be made on this part of his work.

The detailed summaries of the comments and explanations given by his subjects are obviously instructive. To the psychiatrist, they are instructive chiefly for the reason that they illustrate, probably very well, how far and in what forms the mechanisms of psychopathology have gained admission to the awareness of a group of individuals of

average intelligence. In this particular, however, we are somewhat hazy because we do not know to what extent the author himself has infused into the summaries a much better than average understanding of these mechanisms. On the whole, though many of the summaries are painfully superficial as interpretations, they do not seem to warrant the inference that a futile and vapid type of explanation of behavior motivation is on the retreat.

It is not for the psychiatrist to discuss the question whether this paper is or is not good psychology. However that may be, the author has shown an admirable ingenuity, detachment, and fairness, and there are throughout the monograph brief discussions and references that are instructive. A bibliography of 74 items is appended.

G. S. Amsden.

Cornell Medical College.

Le Banc des Pénitents: Étude Psychologique sur l'Œuvre de la Conversion a l'Armée du Salut. By G. Swarts. Paris: Librairie Philosophique J. Vrin, 1931. 147 p.

This is an objective psychological analysis of the organization and procedures of the Salvation Army. The author applies to her study an almost behavioristic technique, concentrating almost exclusively upon actual procedure at revivals, consecrations, "experience" meetings, individual conferences, and so forth. In every case, the analysis of the psychological reasons determining these procedures is based upon statements made to and by the officers of the Army themselves, notably in their books of instructions, from which numerous citations are made.

The analogy of the army is consistently carried out. The three chapters composing the first part of the book answer the question, What is the Salvation Army? Here (1) a typical Salvation Army meeting is described in a general way; (2) the ardent and forceful personalities of William and Catherine Booth are portrayed in connection with their work of founding the Army; and (3) the doctrines and rules of the Army are psychologically discussed.

The second section of the book describes the "tools of combat" used in the "war for salvation." These tools include exhortations in great meetings, testimony by converts, prayers, songs, and special personal work with those individuals who seem to be favorable subjects for conversion.

The last section of the book is devoted to a more detailed analysis of the fight itself, discussing the general religious atmosphere of the meeting, the way in which the suspense and emotion are gradually worked up and worked upon, and the cumulative "drive" by which

the officers bring about a "conviction of sin" and a surrender to the emotional forces of religion.

The *Leitmotif* of the entire book is the practical efficiency and the accurate psychological judgment with which even the smallest detail of the work of the Salvation Army is planned, conducted, and supervised. Particular emphasis is laid upon the clarity with which Salvation Army leaders understand, and allow for, the fact that the work of saving a soul has only just begun when the "mourner" has been brought to the "sinner's bench."

Special interest is lent to this study in religious psychology by the clear picture that the author has been able to draw of the Salvation Army as adapted to continental temperaments and conditions. On the whole, the amount of modification required seems to be astonishingly slight, although one gathers that the public to which the Salvation Army makes a successful appeal is smaller, in proportion to the population, on the European continent than it is in the United States.

E. Marion Pilpel.

New York City.

The Climacteric (the Critical Age). By Gregorio Marañon, M.D. Translated by K. S. Stevens; edited by Carey Culbertson, M.D. St. Louis: C. V. Mosby Company, 1929. 425 p.

In this useful book the author has attempted an understanding of the climacteric, not as a genital episode, not as an incident of the sexual life more or less accompanied by reactional symptoms on the part of the other apparatus of the economy, but as a stage of organic evolution, perfectly characterized, anatomically and physiologically, in whose center the extinction of active genital life stands out prominently, yet which is not limited to this genital extinction.

The material is presented in outline form in twenty-seven chapters, dealing with the etiology, the symptomatology, and the treatment of the disorders of the climacteric. The bibliography is thoroughly adequate and a stimulus to further reading.

The author characterizes this physiologic epoch as an "endocrine crisis," and calls attention to the fact that the pathogenetic mechanism of the symptomatology is not limited to insufficiency of the genital glands, as has been held by certain writers, but is the expression of a complex endocrine readjustment which varies in different individuals. The thyro-ovarian synergy is well discussed from a physiological standpoint, as well as in relation to the involutional phase. Hypophyseal cachexia and suprarenal hyperfunction are stressed as large contributing factors in the symptomatology. The

author uses the term "pseudo-hyperthyroid vegetative neurosis," which expresses his conception of the biophysiological basis of the menopausal disorders.

An attempt to link up psychic with biological alterations in the organism is to be noted throughout the book, and on the whole a very rational approach is made. The scope of this view can be appreciated from the following quotations:

> "The endocrine-vegetative system undoubtedly takes part in the development of the emotional act, although the kind of intervention is controversial. In the critical age the endocrine-vegetative system usually acquires a degree of functional tension which makes it particularly fit for emotional receptivity. As this physiological condition coincides with a parallel social condition—that is, with the increase of emotional attacks—the organism is frequently profoundly affected through psychic impulses."

> "In general, man, and especially woman, drags through life the chains of sex. On one side, as we have seen, sex acts in an effective and direct way upon the whole of his being. And on the other side, man himself has woven about sex a fabric of myth which makes his slavery narrower and more restricted. The fact is that throughout the whole of each human life we can easily see the traces of sex energy, not only in those activities which appear linked directly with it, but also in others—as those dependent on the physiologic life, which have no apparent reference to sex. It is clear that of all sexual moments it is the one of its extinction that leaves the deepest trace upon the nervous system which has been thus prepared."

In his conception of certain of the perversions, the author attempts to work out the relation between the "original organic homosexualism" and Freud's "original psychic homosexualism." He scores Freud for not wishing to link these two fundamentals.

In the discussion of psychic aberrations occurring during the climacteric, an excellent differentiation is made between those dependent on endocrine factors and those merely coexistent with endocrine complicating factors. The sound psychiatric approach is seen in the author's statements that "menopausal psychopathics appear in women with markedly morbid nervous (neurotic) predispositions," and that latent epileptic or other neuropathic tendencies may be brought to the surface under the stress of the menopause—that is, that in many instances the physiologic stress of the climacteric may act as a provocative element in neuropathic or psychopathic reactions.

There is discussion of some of the errors commonly made in dealing with middle-life disorders. For example, the author calls attention to the fact that the climacteric crisis may appear long before the menses are disturbed.

Therapeutic measures are dealt with competently, and it is in-

teresting to note that the author advises psychotherapy as the procedure of primary importance. Glandular therapy also is discussed, with sound advice as to dosage and accurate standardization.

HAROLD D. PALMER.

Institute of the Pennsylvania Hospital.

SAFETY ON THE "EL." Boston: Boston Elevated Railway, 1929. 190 p.

This is the report that the Boston Elevated Railway Company presented in 1929 in competition for the Anthony N. Brady Memorial Medal, and that won it the award for having made the most outstanding progress in reducing accidents. The report is a sizable volume of 190 pages, including many graphs, charts, and photographs. To any one interested in the problem of accident prevention, the book is well worth reading, for it presents in a thoroughgoing manner the many different angles from which such a problem must be attacked.

Beginning with the need for securing the coöperation of the public —since no railway company alone can prevent all accidents—and for training school children in cautious habits when crossing streets, the report describes in detail, with photographic illustrations, devices and methods for improving tracks, maintenance, and equipment.

Much of the report is of a special interest only to those who are concerned with railway-engineering problems, but there are two sections that the readers of MENTAL HYGIENE would find of particular interest. These are the sections that have to do with the human factors involved in accidents—the study of accidents from the point of view of the operators.

In 1922, Boyd Fisher published a book entitled *Mental Causes of Accidents.*[1] With the exception of the early experiments of Münsterberg, perhaps no other single piece of work tended so much to focus the attention of the lay public upon the relationship between accidents and the men who have them. Psychologists had for some time been working on experimental apparatus—Piorkowski and Stern in Berlin, Lahy in Paris, and Viteles and Shellow in Milwaukee—that would select the men more liable to accidents and make possible an analysis of the various abilities and disabilities among those who were having more than their share.[2] Articles published in the *Per-*

[1] Boston: Houghton Mifflin Company.

[2] This is contrary to the statement on page 79 of *Safety on the "El"*: "A psychological laboratory was, therefore, set up. After preliminary studies during the latter part of 1928, men were put through tests in the laboratory to secure further information about their mental make-up. This is a new departure in street-railway procedure in handling men already in service."

sonnel Journal of July, August, September, and October, 1925, show clearly that the mental causes of accidents, as applied to the transportation industry, have been investigated in psychological laboratories during the past ten years.

The study in Boston made by Dr. Charles Slocombe under the direction of the Psychological Corporation reëmphasized the fact that certain trainmen were "accident-prone."

There were two approaches to the problem. One was a mass approach which considered the accident records of a large group of men and divided them into high- and low-accident men. Various personal data were then studied in these two groups. It was found, for example, that "low-coasting" men were more liable to accidents than "high-coasting" men—in other words, that those operators who tended to save power—the economical operators—were also the safer operators.

A second significant discovery relating especially to men over fifty years of age was that the incidence of accidents among men with abnormal blood pressure was considerably higher than in those with normal blood pressure—in fact, almost twice as high. Furthermore, the study showed that "the man who tends to have many slight accidents which are themselves relatively unimportant" is also the man who tends eventually to have serious accidents. It was found that the following classes of men may be regarded as more than ordinarily prone to accident:

1. Those who do not operate economically, as shown by low-coasting records.
2. Those whose record of delinquencies is long.
3. Older men with abnormal blood pressure.
4. Younger men with very limited experience.

Very excellent work was done in retraining men whose accidents were due to faulty operating habits which had been acquired during years of service and had not been sufficiently checked. The factor of retraining old employes is coming more and more to the front when one deals with problems of increasing safety and reducing accidents. In every industry there are large groups of employes who were trained before modern methods were introduced and who have never been brought up to standard in their performance. These men are often responsible for a large number of accidents.

The second approach was an individual clinical approach. There was found to be a small group of men who were responsible for a large number of accidents. These were examined by specially devised apparatus aimed to discover degree of adaptability to conditions, types of equipment, reaction time to sound and light, powers of concentration,

and judgment of speed and distance. The tendency to *perseverate* was found to be a contributing factor in the case of many of the operators. By this is meant that the operator could not quickly take his mind off of a past happening and focus it upon the immediate situation. Reaction time that was sporadic and eccentric was also found to be a contributing factor, whereas fewer accidents were found among those whose reaction time was steady and often somewhat slower.

Section III describes in detail, supported by statistical tables, the results of the psychological investigations.

The success of the Boston experiment has stimulated other railways as well as industries of an allied nature to focus their attention somewhat more closely upon the accident-prone man and to recognize the truth of the statement so frequently made that 90 per cent of industrial accidents are due to man failure rather than to defects of equipment.

SADIE MYERS SHELLOW.

Milwaukee Electric Railway and Light Company.

THE CRAVING FOR SUPERIORITY. By Raymond Dodge and Eugen Kahn. New Haven: Yale University Press, 1931. 69 p.

This attractive little book is by a professor of psychology and a professor of psychiatry in Yale University, the former perhaps the dean of "experimental" psychologists in America, the latter one of Kraepelin's more distinguished pupils, whose psychiatric thinking is based mainly on the relatively conservative Kraepelinian foundations. The issue of essays like these from such authorship may be a little puzzling, but is scarcely less interesting on that account. The theme divides into the nature of genuine superiority and inferiority and feeling of superiority or inferiority, and the cravings therefor. The general point of view is necessarily purposive.

The essays are perhaps distinguished rather for lucidity and elegance of form than for content. As a *Leitfaden* for mental hygiene to the cultivated reader, the work has " genuine " value, and this is presumably the audience addressed. From this standpoint there is really no criticism, save that the portion on the "C.A." (pp. 51ff) seems to represent an intrusion of personal complexes and to be out of place in a volume of the level, intellectual and æsthetic, maintained elsewhere.

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NOTES AND COMMENTS

Training in Psychiatric Nursing at Henry Phipps Clinic

In a recent number of *The Johns Hopkins Nurses Alumnæ Magazine,* Bernadette A. Mullin, supervising nurse at Henry Phipps Psychiatric Clinic, outlines the course for student nurses evolved by the associate professor in psychiatry, Dr. Esther Loring Richards, which is proving of great practical value to the students assigned to the clinic in their senior year.

"As an initial step toward the comprehension of the psychic phases shown in her patients, each student is required to write out a personality study of herself, using as a guide a very simple questionnaire. . . . Thus she has established a norm with which she is entirely familiar.

"This personal analysis is followed by a course of eleven lectures on clinical psychiatry, with demonstrations of typical patients to illustrate the various forms of mental disorders. The types discussed are those coming under the following classifications, namely:

"(a) The organic deficits acquired through focal or diffuse brain destruction as in paresis, senility, etc.

"(b) Those associated with inadequate development, as in the mentally retarded and the feebleminded.

"(c) Delirious and hallucinatory reaction types in conjunction with acute injection of drugs, alcohol, and the like.

"(d) The affective group, under which we place manic excitement and depression.

"(e) Schizophrenia or dementia praecox.

"(f) The minor psychoses, which include neurasthenics, hypochondriacs, obsessive reaction types, ruminative tension states, and hysteria.

"This course of lectures is followed by five periods of discussion on mental nursing, comprising the history and development of mental nursing, nursing ideals, qualifications, occupational therapy, hydrotherapy, and an explanation of the routine nursing care of special types of disorder, demonstrations of special treatments, and charting.

"Two elective courses of ten hours each, available in the intermediate year are:

"1. Problems common in faulty adjustments of childhood. This course deals with unusual mental reactions and poor adjustments as seen in children.

"2. Mental hygiene concerned particularly with mental condition of adults.

"For the practical application of their studies, the students are assigned in their senior year to a period of ten weeks of routine work in the wards of Phipps Clinic."

The question often comes up as to whether it is better to initiate the inexperienced student on the quiet ward or on the disturbed ward. There are points on both sides. On the one hand, the violence and excesses of disturbed cases are likely to arouse the novice's instinctive fear of the abnormal, and she is inexperienced in handling the emergencies that frequently arise. On the other hand, the disturbed ward offers her the better opportunity to observe mental types that are obvious and consequently more readily interpreted, and her assignment to the quiet ward is sometimes unsafe for the patients since, because of her lack of experience, she may fail to detect or to realize the significance of the more subtle, less positive symptoms presented by these cases. The policy of the Phipps Clinic has been to start the student among the quieter groups, wherever practicable.

> "In the operation of this policy we have not met with any serious problems thus far," Miss Mullin states. "Our wards are quite small and we have a larger staff of nurses and attendants than the average hospital, all of which gives to the student nurse, entering upon this work, a sense of protection, leaving her mind free to take full advantage of the opportunities offered for observation and study.
>
> "During their stay in the clinic, they serve on each ward a period sufficient to become thoroughly acquainted with the various types of cases and their particular treatment, and are assigned also a short term of night duty. Besides this valuable nursing experience, they spend two weeks in the occupational-therapy department and one week in the hydrotherapy department, thus rounding out a full measure of training.
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> "Since the establishment of group nursing at the Phipps Clinic in 1928, pupil nurses do not participate in the care of private-ward patients, but we have found that the elimination of this experience has not proven limiting or detrimental to the students' training.
>
> "In addition to the formal lecture courses given in the intermediate year, there has been established a system of weekly conferences between the interne and nurses on problems relative to the patients of his ward, and between resident physician and nurses on special cases, with exhibition of typical patients to illustrate the various phases of the disease under discussion. These conferences are informal, and the novice is thus afforded an opportunity to ask questions and thus clear up definitely whatever perplexities may be bothering her. By this plan, the student has the exceptional opportunity to correlate her theory and practical knowledge.
>
> "Particular attention is given to charting. We have adopted a system of carefully planned and comprehensive charts. At the end of each day a written narrative report on each patient is required. In this way a full and true picture of the patient's condition during the twenty-four-hour period is portrayed. From this daily narrative a graph is developed which gives a clear picture of the progress of the patient's condition. The physicians of the hospital consider this charting system to be of great assistance to them in the diagnosis and treatment of their patients. . . .

"The training given at Phipps Clinic stresses the importance of regarding the individual patient as a whole, as a psychobiological entity, in order that the student should not fall into the error of considering the mental and physical beings as separate and unrelated functions. . . .

"We endeavor to convey to the student that psychiatry is not the fantastic, mysterious, and bizarre system of magic that so many of the uninformed erroneously suppose it to be, but a well-defined science, not always easy of solution, but a serious and thoughtful application of the growing fund of medical knowledge for the ills of life, resulting from incompatible conditions acquired by ourselves, or thrust upon us by others, or from the mismanagement of life's problems that almost all of us have met or will encounter.

"While it is possible to direct students, to emphasize certain points of importance, to convey to them certain facts regarding the complicated workings of the human mind, and to demonstrate the typical development of various classic examples of mental disorders, yet the real test of the excellence of good mental nursing depends upon the nurse's basic endowment, both intellectually and spiritually. It is her capacity for the broad understanding of human beings, the ability to translate that perception into practical helpfulness, together with an abundant fund of charity and tolerance—coupled necessarily with the ability to put these fine and desirable attributes into action—that will make of her the ideal mental nurse."

Expression and Restraint

The extract below was taken from the concluding section of a study by Dr. W. S. Taylor, in which he gives the results of an investigation conducted by him with the aid of the Social Science Research Council. The study, which is entitled, *A Critique of Sublimation in Males; A Study of Forty Superior Single Men,* is one of the Genetic Psychology Monograph series.

"The psychology of restraint and expression, of 'repression' and 'catharsis,' is very complex. That perpetual hunger leads to a morbid interest in hunger's satisfaction is clear enough, but that unregulated and egoistic gratification of appetite prevents morbidity does not follow at all. One of the most difficult types of patient with which the psychotherapist has to deal is the individual who knows no more than his immediate self-interest, who has no perspective of values, and who comprehends no relation of himself to the social order. People who feel 'emancipated' enough to enter freely upon sex experimentation, with the result that they find themselves ensnared in various sorts of dissatisfaction, are significant cases of failure to organize life.[1]

[1] Cf. F. Dell's *Love in the Machine Age: A Psychological Study of Transition from Patriarchal Society* (New York: Farrar and Rinehart, 1930), pp. 77–80. Hamilton has reported somewhere several interesting examples of this sort of unhappiness. Other cases are described by B. B. Lindsey and W. Evans in *The Companionate Marriage* (New York: Boni and Liveright, 1927), pp. 36–42.

"We must remember, too, that 'the difficulties in adjustment to lack of affection and to the upsetting effects of the sex drive at its physiological level may be occasioned more by lack of ability to assign relative values, to judge fairly one's differences in attractiveness, equipment, behavior, and opportunity, than by limitations of actual emotional and physical needs.'[1]

"Professor David Camp Rogers, who, as a psychologist, has been consulted by persons of various ages about emotional and social adjustments, writes:

" 'It is a unique characteristic of the human race that in this species sex excitability and the capacity for sex activity are present almost continuously after maturity and prolonged considerably beyond the years of child-bearing. It is improbable that a feature so elaborate and so strongly established can have developed except through connection with some important biological advantage. The general advantage in this case is evidently related to the prolongation in the human race of the period during which offspring are dependent on parents for food, protection, and training. The intense and pleasurable emotions of sex tend to develop and perpetuate an attachment between two mating individuals and to reënforce the motivation for work done and sacrifices incurred by each in connection with the other and with their family group. Through the entire period of history, so I infer, sex emotion, operating in family relationships, has been one of the great factors in the work carried out by each generation for the next, and in group ambition toward progress.

" 'I have personally deplored the part that psychologists and sociologists have played, in reviving as features of an avowedly scientific point of view (though it is unsupported by new evidence), the to me fallacious sophistries of Greek thinkers which hold that since every purpose has certain relations to the individual mind, no purpose is more altruistic than any other, and that since pleasures and displeasures have a part in the development and consequences of all purposes, all purposes are in an entirely equal degree purposes aimed at the achievement of pleasure or avoidance of displeasure. I have also regretted the part these same groups have taken in contributing to the more specific popular idea that sex restrictions are mostly unreasoned taboos which should not be allowed by intelligent people to interfere with gratification of strong sex impulses. To me the experiment in assuming freedom for sex gratification apart from attachments intended as permanent, which many in the present generation are carrying on, seems on the whole an extravagant and foolish one. . . .

" 'It is my strong conviction that a considerable number of those who have taken this new liberty have gotten into more emotional difficulties than they have escaped, and that there has been already a large loss

Cf., similarly, S. Normand's *Five Women on a Galley* (New York: The Vanguard Press, 1929); E. Mayo's "Should Marriage be Monotonous?" in *Harper's Magazine*, Vol. 151 (September, 1925), pp. 422–23; and W. Lippmann's *A Preface to Morals* (New York: The Macmillan Company, 1929), pp. 302 ff.

[1] G. H. Preston in *Mental Hygiene Factors in Parenthood and Parental Relationship*. MENTAL HYGIENE, Vol. 12, October, 1928. p. 756.

for social motivation and general happiness resulting from this change in customs.'[1]

"Human nature is not set forth fully by psychoanalysis, nor by this or that extreme 'school of psychology,' alone; and the findings of general psychology run in no way contrary to the conclusion of the ethicists that life is a complexity of interests, and that living involves the integration of these interests, not the satisfaction of some through the destruction of others. Thus although various data[2] indicate that the enforced celibacy of youth to-day represents, in itself, a decrease rather than an increase of life, this decrease may be necessary, under present social conditions, to avoid greater forms of decrease. As Everett puts it, 'I cannot have the experience of being a law-abiding citizen and a thief, a servant of ideal causes and a pander to vice, a lover of enlightenment and an obscurantist. And should I attempt to experience all these modes of life in succession, there are grave, not to say insuperable, obstacles in effecting a transition from one to the other. It is also to be remembered that the deliberate choice not to have a given experience is itself an experience—an experience which, for the total meaning of life, may be one of the best and richest.'[3]

"The increasing emancipation from taboos of unreason demands at once a wise conservatism in practice and a deeper understanding of good and evil. This implies an appreciation of scientific ethics as a human enterprise of the first importance; an enterprise the spirit of which appears in Democritus' saying that 'an evil and foolish and intemperate and irreligious life should not be called a bad life, but rather dying long drawn out.'"

Marriage Health Certificates in Turkey

The regulations published last year by the Turkish government with regard to the issuance of marriage health certificates are discussed in a recent number of the *Journal of the American Medical Association* in a report from its regular correspondent in Turkey:

"Syphilis as a social menace in Anatolia may be traced to the beginning of the nineteenth century, when the establishment of compulsory military service brought the youths from the villages into the cities. With the movement of troops during the latter half of the century, a definite increase in syphilitic infections was noticed. On the other hand, civilians engaged in commerce who went to Russia and the Caucasus and those who had gone there for employment as workmen or bakers brought back the disease to their native provinces, in particular those along the Black Sea. In these provinces, Prof. Duhring Pasha from Germany, about thirty years ago, made investigations for the government, for as the result of syphilis the decrease of births had become alarming and whole villages had become extinct. As a sequel to the

[1] Personally communicated. Cf. similarly M. J. Exner, in *The Sexual Side of Marriage*. New York: W. W. Norton Company, 1934. pp. 200 ff.

[2] Including the present study.

[3] W. G. Everett in *Moral Values*. New York: Henry Holt Company, 1918. p. 329.

World War, with its increase in low morals and poverty, syphilis increased in most large cities.

"May 6, 1930, the general public health law was published, according to which a health certificate is required of all men and women in order to procure a marriage license. The regulations published August 17, 1931, read as follows:

"Physical examinations for marriage health certificates are made gratuitously at all health departments or other government health agencies. Only the health officer is authorized to make such examinations, which are to take place only on the premises of a health department or other government health institution. A marriage health certificate issued by a private physician or a physician connected with an official agency, but who is not a health officer, is not valid unless signed by the local health officer. Before signing a health certificate, the health officer is to consult the records in order to ascertain whether the applicant has at one time been suffering from one of the diseases making marriage prohibitive according to articles 123 and 124 of the general public-health law. Health certificates not bearing the official seal or signature of the health officer are not valid.

"In addition to investigating the general health condition of the applicant, symptoms of venereal diseases, leprosy, mental disease, or trachoma are to be looked for. If men are concerned, special attention is to be given to the mucous membrane of the cheek and lips, the tongue and beneath the tongue, the gums, the palate and the throat, the skin of the thorax, abdomen, and back, the axillary glands and the glands of the groins and the elbow, the knee reflexes, and in particular the generative organs with regard to the presence of secretion. If women are concerned, examination of the mouth is to be made in the same way, and if the applicant has not previously been married, only the elbow glands are to be examined besides. If during the examination symptoms are noticed of a disease which according to the law does not permit marriage, or if doubt arises as the result of such examination, a more thorough method is to be employed.

"In case tuberculosis is suspected, the percussion and auscultation method is to be used and sputum is to be obtained from the applicant in the presence of the physician. In case syphilis is suspected, blood for a test, and in case gonorrhea is suspected, secretion is to be obtained and forwarded to a government laboratory.

"In case leprosy or a mental disorder is suspected, the applicant is to be seen by a specialist. If it has not been possible to make laboratory examinations for the reason that a laboratory was not available, the physician is required to mention this fact in his report. Specimens are to be forwarded for examination in a sealed package accompanied by a note in a closed envelope and forwarded by a person other than the applicant. The results of the laboratory examination are to be made known to the health officer also by a written note contained in a closed envelope conspicuously bearing the word 'personal.' If as the result of the examination a disease is diagnosed which according to the law makes marriage prohibitive, the applicant is refused the health certificate and the physician is to forward the records to the health officer, who is to take further charge of the applicant.

"Such persons may not get married unless the danger of contagion has been eliminated or the disease definitely cured as the result of scientific treatment, which fact is to be proved by a health certificate.

"In case Koch bacilli have been found or the clinical picture is one of active tuberculosis or tuberculosis of the larynx, the applicant is refused the certificate and advised to postpone intentions for six months; if at the end of that time the applicant's condition has not improved, a further postponement for six months is to be decided on and the health officer is required to advise both parties as to the nature of the disease and the consequences involved in contracting marriage under existing conditions.

"Examinations for marriage health certificates are to be given the same prompt attention as emergency cases. A specialist to whom an applicant is sent for final diagnosis and also the physician to whom specimens are forwarded are required to give precedence in the order of examination and carry out such examinations promptly.

"Physical examinations made at government health departments are to be made without the presence of a third person, and the physician is not to divulge the results. Women are permitted to have a relative or a friend present at such examination.

"Private physicians examining applicants for marriage health certificates are required to conform to these regulations. A private physician must not issue a marriage health certificate if the applicant has not presented sufficient evidence as to identification or without having examined the applicant. Any physician not acting in conformity with these regulations is liable to punishment according to decisions of article 282 of the general public-health law, but if, according to the Turkish penal code, the offense deserves more severe punishment, the decisions of the penal code are applied. These regulations have been approved by the council of state, ratified by the council of ministers, and are valid from the date of publication, August 17, 1931."

Biology and the Human Spirit

Editorial, *The New York Times*

Along with other Victorian relics which self-elected best thinkers sought to lay away in the attic after the World War was a certain humanitarianism which flourished along with what-nots, family albums, antimacassars, and haircloth sofas. In their somewhat stuffy way, Victorians concluded that evolution proved the world to be growing better, and confidently believed that they were hastening the process when they treated the sick, the poor, the insane, the incapable, and even the criminal with rather more consideration than had previously been the custom. But they were put in their place by a post-war school of popularizers who read a little of the new biology and then loudly proclaimed that humanitarianism was all spinach. Heredity, it was announced, was everything, environment nothing. Consequently it was of no use to be indulgent to the de-

fective after they were born. The only way to improve the human race was to prevent them from being born.

The advantage of a creed like this to one who is himself conscious of being superior is obvious. He may look forward to the day when the world will be redeemed from misery by being peopled by individuals very much like himself. He need not worry over the sufferings of the poor, for they are nature's way of eliminating bad human stock. The inequalities of rank, wealth, and social position need not depress him; they are nature's way of encouraging the better human stock. He may conscientiously despise the weak—does not nature despise them? He may conscientiously bow before Caesar and Midas—does not nature also bow before them?

At present, however, this neo-paganism is, according to those who know most about genetics, wide of the facts. The latest testimony comes from Professor H. S. Jennings of Johns Hopkins. He has written a book on "The Biological Basis of Human Nature", in which he sets forth what is known to-day about heredity. He also sets forth what is not known. Biology is strangely impartial. It does not give credence to the theory of Dr. Watson that "all individuals are fundamentally alike," though it does accept his experiments as showing that proper environment can make up for many of the deficiencies of a faulty heredity. But it does not accept Dr. Wiggam's ingenuous notion—the words are Dr. Jennings'—that "intellectuals produce intellectuals; genius produces genius; morons produce morons; good people produce good people; criminals produce criminals; that each grade of ability, of superiority or inferiority, reproduces itself." If this were indeed true, we might begin breeding supermen to-morrow. But in most cases we cannot tell from the outside who has good heredity and who has not. Sensible people do, it is true, produce more sensible children to the million than foolish people do. But because the vast bulk of humanity is neither extraordinarily wise nor extraordinarily silly, the overwhelming number of defectives, as well as the overwhelming number of geniuses, come from what may be called the biological bourgeoisie. For every feebleminded individual, there are thirty normal individuals capable of transmitting feeblemindedness. Genius may run in the same or a similar ratio. We cannot get model aristocrats by breeding solely from the Social Register, nor intellectual giants by breeding solely from holders of Ph.D. degrees.

What can we do? We can, if we are biologists, go on studying. Some day we may be able to diagnose the latent bad or weak traits in an individual's inheritance and possibly induce him not to have children. Yet bad traits and good traits are often tied up in the same bundle. While waiting for further discoveries to be made, we

can return to the age-old job of improving our environment, and especially the environment of the less fortunate. As Professor Jennings puts it, "measures of public health must be carried out, overwork and bad conditions of living done away with, faults of diet, both quantitative and qualitative, corrected, economic ills conquered, grinding poverty abolished." For superior individuals this is not half so attractive as Dr. Wiggam's prescription. It means hard work, hardest of all for those with superior abilities. The fundamental idea behind it is not new—indeed, it is nearly two thousand years old. Yet it may be humanity's way out. Perhaps compassion is not, after all, an obsolete virtue.

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